BAPTIST ENT SPECIALISTS

Medical Questionnaire (Part I)

Name _____ **Date of Birth** _____ **Date** _____

Name of your primary care physician: _____

Were you referred to our facility by another physician? ☐ **Yes** ☐ **No**

If yes, what is the name of your referring physician? _____

Occupation

If desired, please indicate your current employment status.

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Student

Employer: _____ Occupation: _____

Pharmacy

It is common for our physicians to prescribe medications to aid in patient treatment. Please list a pharmacy of choice.

Name: _____ Phone Number: _____ Fax Number: _____

Street Address: _____ Ste/Unit: _____

City: _____ State: _____ Zip: _____ Mail Order: ☐ **Yes** ☐ **No**

Reason for Visit

Summarizing the reason for your visit will assist in the efficiency of your visit. Please answer the questions accordingly.

Please briefly describe the **PRIMARY** reason for your visit with our facility: _____

_____

Please briefly describe the **SECONDARY** reason for your visit (if applicable): _____

_____

Briefly describe when your symptoms began: _____

Have your symptoms gradually become worse? If so, provide a brief time frame: _____

Testing

Please mark any of the following tests that RECENTLY have been conducted to further diagnose your medical concern.

☐ **No Prior Testing**	☐ Diagnostic Imaging (CT Scan or MRI)	☐ Lab work/Blood work
☐ Allergy Testing	☐ Endoscopy	☐ Sleep Study
☐ Biopsy	☐ Hearing Test	☐ Other: _____

Treatment

Please mark any of the following tests that RECENTLY have been conducted to further diagnose your medical concern.

☐ **No Prior Treatment**	☐ Antihistamines	☐ Oral Steroids
☐ Allergy Shots/Immunotherapy	☐ Ear Drops	☐ Reflux Medications
☐ Antibiotics	☐ Nasal Sprays	☐ Other: _____

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Medical Questionnaire (Part II)

Please Note: the following questions regard your medical/surgical history, medications, allergies, and medical issues. It is imperative that the following information is completed to the best of your knowledge. Failure to provide pertinent details will impede on your treatment and/or may cause harm to your wellbeing.

Medical History

Indicate any past or active medical issues from the list below. Additional unlisted history can be noted under "other."

	Past	Active		Past	Active		Past	Active
No Medical History	☐	☐	Depression	☐	☐	Kidney Disease	☐	☐
Allergy Shots	☐	☐	Diabetes	☐	☐	Leukemia/Lymphoma	☐	☐
Anemia	☐	☐	Ear Infections	☐	☐	Lung Disease	☐	☐
Anxiety	☐	☐	Environmental Allergies	☐	☐	Migraine Headaches	☐	☐
Arthritis	☐	☐	Emphysema	☐	☐	Neurological Disorders	☐	☐
Asthma	☐	☐	Esophageal Reflux	☐	☐	**Type:** _____		
Autoimmune Disease	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐
Type: _____			Heart Disease	☐	☐	Pregnancy	☐	☐
Bleeding Disorder	☐	☐	Hepatitis	☐	☐	Sleep Apnea	☐	☐
Bronchitis	☐	☐	**Type (A, B, or C):** _____			**CPAP Use**	☐	☐
Cancer	☐	☐	HIV/AIDS	☐	☐	Sinus Infections	☐	☐
Type: _____			High Blood Pressure	☐	☐	Stroke	☐	☐
Congestive Heart Failure	☐	☐	Hyperthyroidism	☐	☐	Thyroid Disease	☐	☐
COPD	☐	☐	Hypothyroidism	☐	☐	Others:		

Past Surgical History

Indicate any past surgical procedures from the list below. Additional unlisted surgeries can be noted under "other".

☐	**No Surgical History**	☐	Hysterectomy	☐	Sinus Surgery
☐	Adenoidectomy	☐	Nasal Surgery		**Type:** _____
☐	Cardiac Stent(s)		**Type:** _____	☐	Skin Cancer Removal
☐	Carotid Artery Surgery	☐	Open Heart Surgery	☐	Spine Surgery
☐	Ear Tubes	☐	Orthopedic Surgery	☐	Thyroid Surgery
☐	Ear Surgery		**Type:** _____	☐	Tonsillectomy
	Type: _____	☐	Septoplasty	☐	Tubal Ligation
☐	**Other(s)** _____				

Family History

Indicate any of the listed conditions that apply to your family.

	Deceased	No History	Unknown	Easy Bleeding	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer	Mental Illness	Hearing Loss
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Medical Questionnaire (Part III)

Social History

Indicate if you participate in any of the listed social activities.

Substance	Never Used	Current Use	Former Use	Type	Units Per Day	How Long (Years)	It Stopped, When?
Tobacco Use	☐	☐	☐				
Alcohol Use	☐	☐	☐				
Caffeine Use	☐	☐	☐				
Recreational Drug	☐	☐	☐				

Allergies List

List any medications or substances that you are sensitive or allergic to.

☐ **No known drug allergies**		☐ Erythromycin	☐ Lidocaine	☐ Opioids	☐ Sulfa
☐ Afrin	☐ Codeine	☐ Latex	☐ NSAIDS	☐ Penicillin	☐ Tetracycline
☐ Cephalexin	☐ CT Contrast	☐ Others: _____			

Medication List

Patients are welcome to provide printed list of medications rather than rewriting the information below.

Baptist ENT Specialists now share records with Baptist Primary Care. In general, a list of medications can be printed and reviewed at the time of the visit. (This applies only if the patient recently reviewed the medications with their primary care physician)

Otherwise, list all medications; including aspirin, herbal medicines, vitamins, and diet pills that are taken daily.

☐ I am a current patient of Baptist Primary Care and will review a printout of my medications at the time of my visit.

☐ I have provided my own list that I have verified is accurate to the best of my knowledge.

Medication	Strength	Frequency	Reason

BAPTIST ENT SPECIALISTS

Medical Questionnaire (Part IV)

Current Issues (Review of Systems)

Indicate any current issues from the list below. Additional unlisted issues can be noted under "other."

Allergic/Immunologic
- ☐ Environmental Allergies
- ☐ Itchy/Burning Eyes
- ☐ Sneezing
- ☐ Other: _____

Ear Surgery
- ☐ Chest Pain
- ☐ Irregular/Rapid Heartbeat
- ☐ Palpitations
- ☐ Other: _____

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Other: _____

Ears
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Fullness/Pressure
- ☐ Ear Pain
- ☐ Excessive Ear Wax
- ☐ Hearing Loss
- ☐ Itchy Sensation
- ☐ Ringing/Noise in Ears
- ☐ Other: _____

Ears
- ☐ Heat or Cold Intolerance
- ☐ Significant Weight Gain or Loss
- ☐ Other: _____

Eyes
- ☐ Visual Change
- ☐ Other: _____

Falls Within Past Year
- ☐ No Falls
- ☐ 1 fall with injury
- ☐ 1 fall **without** injury
- ☐ 2 or more falls with injury
- ☐ 2 or more falls **without** injury

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Other: _____

Hematologic Lymphatic
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymph Node Enlargement
- ☐ Other: _____

Integumentary
- ☐ Rash
- ☐ Other: _____

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Other: _____

Neurological
- ☐ Numbness
- ☐ Poor Sleeping
- ☐ Other: _____

Other/Miscellaneous
- ☐ Other: _____
  _____
  _____

Nose/Sinus
- ☐ Clear Nasal Drainage
- ☐ Diminished Sense of Smell
- ☐ Discolored Nasal Drainage
- ☐ Facial Pain/Pressure
- ☐ Nasal Congestion
- ☐ Nose Bleed(s)
- ☐ Post Nasal Drainage
- ☐ Other: _____

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

Respiratory
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing
- ☐ Other: _____

Throat/Mouth/Neck
- ☐ Difficulty Swallowing
- ☐ Frequent Need to Clear Throat
- ☐ Jaw Pain
- ☐ Neck Mass
- ☐ Neck Pain
- ☐ Sore Throat
- ☐ Sores/Ulcers in Mouth
- ☐ Throat Fullness
- ☐ Voice Problems
- ☐ Other: _____

Please Note: the presence of any of the symptoms listed above may constitute a serious health issue. Patients should follow up with their primary care physician for any of these symptoms not related to today's visit. If a patient does not have a primary care physician, any Baptist ENT Specialists representative will be happy to provide the names of several in the immediate area. Additionally, patients can visit https://www.baptistjax.com/doctors/baptist-primary-care/locations.

Print Patient's Name	Patient's Signature	Date