CHICAGO
NASAL & SINUS
CENTER

Medical History Questionnaire

PATIENT NAME _____ DATE _____

Please check any medical problem that you have been treated for or are currently being treated for:

☐ Diabetes	☐ Arthritis	☐ Tuberculosis	☐ Coronary Artery Diseaset
☐ Migraines	☐ Asthma	☐ Bleeding Disorder	☐ Hypertension
☐ Stroke	☐ Ulcers	☐ Thyroid Disease	☐ Depression
☐ Cancer	☐ Hepatitis	☐ Kidney Disease	☐ Immune Disorder

Current height: _____ Current weight: _____

Please list any other major illnesses or injuries: _____

_____

Prior surgeries: _____

_____

Contributory family history: _____

Current medications: _____

_____

Medication allergies or adverse reactions: _____

_____

Social History

Do you use chew or smoke tobacco? ☐ No ☐ Yes ☐ Former Smoker

Please quantify (how much, how long, etc.) _____

☐ Never used tobacco ☐ Second-hand exposure ☐ Occupational smoke or inhaled irritant exposure

Do you drink alcoholic beverages? ☐ No ☐ Yes

Please quantify (how much, how long, etc.) _____

Review of Systems

Are you currently experiencing or have you experienced problems with:

☐ Night sweats	☐ Recurrent fevers	☐ Unintentional weight loss	☐ Double vision
☐ Hearing loss	☐ Ringing in the ears (tinnitus)	☐ Chest pain	☐ Irregular heartbeat
☐ Heart murmur	☐ Shortness of breath	☐ Bronchitis/Pneumonia	☐ Emphysema
☐ Chronic cough	☐ Indigestion	☐ Nausea/vomiting	☐ Aspiration
☐ Difficulty swallowing	☐ Diarrhea	☐ Urinary infections	☐ Prostate problems (males)
☐ Pelvic pain (females)	☐ Muscle weakness	☐ Limb or back pain	☐ Eczema or Psoriasis
☐ Vertigo/Dizziness	☐ Seizures	☐ Fainting	☐ Anxiety
☐ Memory loss	☐ Allergies	☐ Anemia	☐ Swollen lymph nodes

Environmental/food allergies to (e.g. dust, mold, pollens, dander, etc.): _____

_____

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