Print Form

SKYLANDS MEDICAL GROUP, P.A.
Otolaryngology - Head and Neck Surgery
New Patient Questionnaire

Patient Name: _____ Birthdate: _____ Date _____

Sex: ☐Male ☐Female

Past Medical History:

☐ High BP ☐ Heart Attack ☐ Heart Disease ☐ Angina ☐ Asthma

☐ Emphysema ☐ Peptic Ulcer ☐ Diabetes ☐ Stroke ☐ Arthritis

☐ Cancer (Type: _____)

Other Problems: _____

Surgical History: _____

_____

Allergies: _____

Medications: _____

_____

Immunization Status: _____

Tobacco Use: _____

Alcohol Use: _____

Drug Use: _____

Review of Systems:

⦿ ☐ Fever ☐ Weight Loss ☐ Chills ☐ Loss Of Appetite ☐ Abnormal Thirst

⦿ ☐ Blurred Vision ☐ Double Vision ☐ Decreased Vision

⦿ ☐ Hearing Loss ☐ Ear Infections ☐ Noises In Ear

⦿ ☐ Dizziness/Vertigo ☐ Abnormal Taste ☐ Abnormal Smell

⦿ ☐ Chronic Cough ☐ Wheezing ☐ Shortness of Breath (☐ At Night Or ☐ On Exertion)

⦿ ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Frequent Heartburn

⦿ ☐ Sore Throat ☐ Sensation Lumps in Throat ☐ Stomach Pains

⦿ ☐ Chest Pain ☐ Fainting ☐ Palpitations ☐ Swelling of Feet

⦿ ☐ Headaches ☐ Numbness ☐ Weakness ☐ Paralysis ☐ Tingling Sensation

⦿ ☐ Easy Bruising ☐ Easy Bleeding

Family History: Has anyone in your family ever had?

Cancer: _____

Diabetes: _____

Heart Attack: _____

Heart Trouble: _____

Stroke: _____

High Blood Pressure: _____

Asthma: _____

Allergies: _____

Vital Signs:

Temp: _____ BP: _____ Pulse: _____ RR: _____ HT: _____ WT: _____

Reviewed by: _____