

**ISAAC NAMDAR, MD
HEAD & NECK SURGICAL GROUP
PATIENT HEALTH QUESTIONNAIRE**

PATIENT NAME: _____ HEIGHT: _____ WEIGHT: _____

REVIEW OF SYSTEMS - CHECK ALL THAT APPLY:

- | | | | |
|--|---|---|---|
| <p>Head & Neck</p> <input type="checkbox"/> Eye Disease
<input type="checkbox"/> Double vision
<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Prior Ear Surgery
<input type="checkbox"/> Ear Ache
<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Nasal Obstruction
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Nasal Discharge
<input type="checkbox"/> Altered sense of smell
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Nasal Polyps
<input type="checkbox"/> Snoring
<input type="checkbox"/> Excessive sleepiness
<input type="checkbox"/> Facial pain
<input type="checkbox"/> Pain with chewing
<input type="checkbox"/> Recent dental work
<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Lumps in the neck
<input type="checkbox"/> Allergies | <p>Respiratory System</p> <input type="checkbox"/> Hoarseness
<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Throat clearing
<input type="checkbox"/> Heart Burn
<input type="checkbox"/> Regurgitation
<input type="checkbox"/> Spitting up blood
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic bronchitis
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Lung cancer <p>Neurologic</p> <input type="checkbox"/> Headaches
<input type="checkbox"/> Head injury
<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Transient black-outs
<input type="checkbox"/> Transient vision loss
<input type="checkbox"/> Seizures
<input type="checkbox"/> Strokes | <p>General</p> <input type="checkbox"/> Night Sweats
<input type="checkbox"/> Fevers
<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Easy Bruisability
<input type="checkbox"/> HIV infection or AIDS
<input type="checkbox"/> Psychiatric Diseases <p>Gastrointestinal</p> <input type="checkbox"/> Difficult swallowing
<input type="checkbox"/> Pain on swallowing
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bloody stools
<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Gall bladder disease
<input type="checkbox"/> Heartburn or ulcers | <p>Cardiovascular</p> <input type="checkbox"/> Hypertension
<input type="checkbox"/> Heart disease
<input type="checkbox"/> Angina
<input type="checkbox"/> Swelling of the ankles
<input type="checkbox"/> Heart surgery
<input type="checkbox"/> Angioplasty
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anemia <p>Endocrine</p> <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heat/cold intolerance
<input type="checkbox"/> Thyroid imbalance
<input type="checkbox"/> Menstrual disorders <p>Urologic</p> <input type="checkbox"/> Difficulty on urination
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Blood in the urine
<input type="checkbox"/> Prostate problems <p>Other</p> <hr/> |
|--|---|---|---|

<p>Past and present medical problems:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Previous surgeries and dates (month/year)</p> <p style="text-align: center;">(/)</p> <p style="text-align: center;">(/)</p> <p style="text-align: center;">(/)</p> <p style="text-align: center;">(/)</p> <p style="text-align: center;">(/)</p> <p style="text-align: center;">(/)</p>	<p>List all current medications and dosages (including OTC):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>Do you smoke?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how much?</p> <p>_____</p>	<p>Do you drink alcohol?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how much?</p> <p>_____</p>	<p>Any other information for Dr.?</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Please list all allergies:
(medications, inhalants, foods, contact allergies) _____

Reason for today's visit: _____

Patient Signature _____	Date _____
Physician Signature _____	Date _____