Philip Chironis, M.D. Medical Corporation
Patient Health Questionnaire

Patient Name: ____ Today's Date: _________

Date of birth: ___________________ Age: ______________

Reason for your visit today: ____

Have you had any of the following: (circle all that apply)

Diabetes, stroke, cancer, heart disease, high blood pressure, kidney problems, lung problems, fractured bones, visual problems, bleeding problems, AIDS or HIV:

If yes to any of the above, please explain: ____

____

Previous Surgeries: ____

Current Medications: (Please list over the counter & prescription medications)

____

____

Allergic to Medications: Please list or mark none if no known medication allergies

____

[ ] NONE

Occupation: __________________________________ How Long? ___________________

Do you smoke cigarettes:	Yes	No	How many packs per day_________
Do you drink alcohol:	Yes	No	How many drinks per week _______
Do you use other substances:	Yes	No	Type: _________________________

Height: ___________ Weight: _____________

How were you referred to our office?

[ ] Physician (please provide name): ____
[ ] Friend/another patient
[ ] Insurance
[ ] Internet/website
[ ] Local advertising
[ ] Other: ____

Patient Signature: ____ Date: ___________
(Guardian signature for patients under 18 years old)

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ENT Questionnaire

Please circle any that apply:

Ears:	Hearing Loss	Left	Right	Both
[ ]	How long have you experienced hearing loss? ________________			
Check, if none	Ringing/Buzzing Noise	Left	Right	Both
	Drainage from Ear	Left	Right	Both
	Ear Pain	Left	Right	Both
	Ear Fullness	Left	Right	Both
	Itchy Ears	Left	Right	Both
	Any prior ear surgeries or treatment? If yes, please explain below:			
	____			

Nose:		
[ ]	Bleeding	How often? ____________________
Check, if none	Congestion	
	Facial pain	
	"Hay Fever"	
	History of broken nose	When? ________________________
	Nasal drainage	
	Any prior nose surgeries or treatment? If yes, please explain below:	
	____	

Throat:		
[ ]	Pain	Pain radiates to another area? __________
Check, if none	Difficulty swallowing	
	Change in voice	
	Tonsillitis	How many times in past 12 mos? _______
	Strep Throat	How many times in past 12 mos? _______
	Post nasal drip	
	Sleep apnea	

Dizziness		
[ ]	Feeling of room spinning	How long is each episode? _________
Check, if none	Imbalance	
	Veering to a side	
	Headaches	
	Migraines	
	Vision changes	
	Tingling/numbness in hands/feet	
	Any prior surgeries or treatment for above conditions? If yes, please explain: ____	

Anything else you think the doctor should know about your health condition/history? If yes, please explain: ____

____

Patient Signature: ____ Date: ___________
(Guardian signature for patients under 18 years old)