Linda D. Dahl, M.D.
Diplomate American Board of Otolaryngology

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Health Questionnaire

Name: _____ Age: _____ Height:_____ Weight: _____ Date: _____

Reason for visit: _____

Drug allergies and reactions: _____

Non drug allergies and reactions:_____

Medications you are currently taking

Name	Dose

Review of Systems (Please mark yes or no for current symptoms.)

		yes	no			yes	no			yes	no
General	Fever			Throat	Soreness			Eyes	Pain		
	Chills				Pain				Vision loss		
	Weight loss				Swallowing problem				Excessive tears		
	Fatigue/malaise				Voice problem				Itching/irritation		
	Sleep problems				Bad breath				Drainage		
	Cough				heartburn			Neck	Lump/mass		
	Headache				Foreign body sensation				Thyroid		
Ears	Itching			Allergy	Urticaria			Respiratory	Wheezing		
	Pain				Hay fever				Excessive sputum		
	Fullness/pressure				Persistent infections				Hemoptysis		
	Hearing loss			Neurologic	Headaches				Cough		
	Wax				Syncope/passing out			Skin	Rash		
	Ringing/buzzing				Seizures				Itching		
	ear drainage				weakness				Ulcers/growths		
Nose	Obstruction			Vestibular	Vertigo (spinning)				Excess scarring		
	Congestion				Dizziness				Bleeding problem		
	Post nasal drip				Joint problems				dryness		
	Facial pain				With head turns						
	Bleeding				While sitting						
	Runny nose										

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Family History *(Please mark if any blood relative has suffered any of the following.)*

Alcoholism		Arthritis		Blindness		Allergies		High cholesterol		Kidney disease	
Anemia		Asthma		Cancer		Hearing loss		Hypertension		Stroke	
Anesthesia problems		Bleeding problems		Diabetes		Heart disease		Migraines		Thyroid disease	

Past Illness *(Please mark if you have had any of these illnesses.)*

Illness	Date of onset

Previous Surgeries *(Please list the name, surgeon, and date of any past surgeries.)*

Name of surgery	Surgeon	Year

Social History *(Please mark appropriate responses.)*

Diet: Omnivore Vegetarian Vegan Other_____

Use of alcohol: Never Occasional/ Social Moderate Daily

Use of tobacco: Never Previously but quit (when):_____ Yes (how many packs per day) _____

Use of recreational drugs: Never Previously but quit (when):_____ Active (what drugs)_____