REQUIRED - ENTIRE FORM MUST BE COMPLETED

The Voice Center

PATIENT QUESTIONNAIRE

PATIENT NAME:_____ **DATE:**_____

Date of Birth: _____ Age:_____ Height:_____ Weight:_____ Gender: Male _____ Female _____

Marital Status:_____ Occupation:_____ Referring Physician:_____

Primary Care Doctor: _____ Pediatrician: _____

ARE YOU CURRENTLY ENROLLED IN HOME HEALTH CARE (do you have home nurse visits, speech, physical or occupational therapy at your home?) Please circle **Y N**

REASON FOR CURRENT DOCTOR VIST: Explain problem/s and duration: _____

_____

PERSONAL MEDICAL HISTORY: Please check all that apply: [] None Apply

[] High blood pressure
[] Diabetes
[] Thyroid disease
[] Heart disease
[] Infectious Disease (HIV, TB, Hepatitis, etc): _____
[] Lung Disease (Asthma, Emphysema, etc): _____
[] Cancer: _____
[] Other (List) _____

REVIEW OF SYSTEMS: Check the appropriate box; if yes, explain briefly below [] None Apply

[] Vision problems
[] Lung problems
[] Heart problems
[] Kidney problems
[] Liver problems
[] Stomach problems
[] Bleeding problems
[] Endocrine problems
[] Musculoskeletal problems
[] Neurologic problems
[] Psychiatric problems
[] Skin problems

Explain if yes: _____

PRIOR SURGERIES: Please list with dates

[] No surgeries

_____
_____
_____

FAMILY HISTORY: List family member and as related to your current problem

_____
_____
_____

MEDICATIONS: [] No Medications

Medication Dose How often taken

_____
_____
_____
_____
_____

Please list others on the back of this sheet

ALLERGIES TO MEDICINES: [] No Allergies

List medicine and reaction

_____
_____
_____

Are you pregnant: [] Yes [] No

If yes, how many months? _____

SOCIAL HISTORY:

City of Birth: _____How long in TX_____
Do you smoke? Y/N If yes, # of packs/day?____ How many years?___
If no, have you ever smoked?_____ When did you quit?_____
Do you drink alcohol? Y/N If yes, how much, how often?_____

PHARMACY:

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone: _____