Atlanta Head & Neck Associates
A Northside Network Provider

DEMOGRAPHIC INFORMATION

Name:
(First) (Middle) (Last)

Preferred Name:	Maiden Name:	Religion (optional):
Date of Birth:	Age:	Place of Birth:
Home Phone:	Cell Phone:	

Do You Have Children? ☐ Yes ☐ No If yes, what are their names and ages?

Spouse/Partner Name:

Do You Have an Advance Directive? ☐ Yes ☐ No If yes, please provide a copy to our office

REASON FOR YOUR VISIT:

SOCIAL HISTORY

Smoking History	☐ Never ☐ Quit	☐ Occasional ☐ Daily	_____ packs/day	How long? _____	Date Quit _____
Smokeless Tobacco	☐ Never ☐ Quit	☐ Occasional ☐ Daily			
Vaping	☐ Never ☐ Quit	☐ Occasional ☐ Daily			
Alcohol History	☐ Never ☐ Quit	☐ Social ☐ Daily	_____ drinks per day/wk	How long? _____	Date Quit _____

Recreational Drugs ☐ Never ☐ Past ☐ Active

Residential Status: ☐ Alone ☐ Lives with family ☐ Lives with friends/roommates ☐ Assisted Living ☐ Nursing Home

Highest Level of Education: ☐ Elementary ☐ Middle School ☐ High School Diploma/GED ☐ College/Undergraduate ☐ Post-graduate

Occupation:

Travel History (please list places & dates of travel outside of the USA):

ALLERGIES

Do you have any medication allergies? ☐ Yes ☐ No

Do you have any environmental allergies? ☐ Yes ☐ No

*Please list all allergies below (include medications, tape, latex, other). Please list *food allergies* in Nutrition History.*

Name of Medication / Allergy	Type of Reaction

MEDICAL HISTORY QUESTIONNAIRE

Name: DOB:

REVIEW OF SYSTEMS			
Please check the appropriate boxes if you **CURRENTLY** have any of the following conditions:			
	√	√	√
CONSTITUTIONAL	❑ fatigue	❑ weakness	❑ fever
	❑ Weight gain without trying If yes, ____lbs?	❑ Weight loss without trying If yes, ____lbs?	❑ body aches
EYES	❑ changes in vision	❑ glaucoma	
EARS/NOSE/THROAT	❑ hearing loss	❑ nose bleeds	❑ sore throat
	❑ difficulty swallowing	❑ neck pain	❑ headaches
	❑ dental problems		
BREASTS	❑ lumps in breast	❑ tenderness in breast	❑ swelling in breast
CARDIOVASCULAR	❑ chest pain	❑ leg pain with walking	❑ leg swelling
	❑ palpitations (irregular heartbeat)	❑ cardiac murmurs	❑ dyspnea (shortness of breath) on exertion
	❑ syncope (fainting)		
RESPIRATORY	❑ chronic cough	❑ shortness of breath	❑ difficulty breathing
	❑ coughing up blood	❑ wheezing	❑ sleep apnea
	❑ swallowing issues	❑	❑
GASTROINTESTINAL	❑ changes in bowel habits	❑ nausea	❑ vomiting
	❑ diarrhea	❑ constipation	❑ abdominal pain
	❑ jaundice	❑ eating poorly because of a decreased appetite	❑ hematemesis (vomiting blood)
	❑ heartburn		
GENITOURINARY	❑ increased urine frequency	❑ painful urination	❑ urinary retention
	❑ blood in urine	❑ urinary tract infection	❑ urinary urgency
	❑ urinary incontinence	❑ testicular pain (male)	❑ lumps in testicles or scrotum (male)
INTEGUMENT / SKIN	❑ itching	❑ nail changes	❑ skin color changes
	❑ rash	❑ dryness	❑ jaundice
NEUROLOGIC	❑ headaches	❑ dizziness/vertigo	❑ numbness/tingling
	❑ seizures	❑ tremors	
MUSCULOSKELETAL	❑ muscular weakness	❑ muscle aches/pains	❑ join pain/stiffness
	❑ joint swelling	❑ decreased range of motion	❑ bone pain
ENDOCRINE	❑ heat/cold intolerance	❑ increased thirst	❑ increased urination
	❑ excessive sweating		
PSYCHIATRIC	❑ anxiety	❑ depression	❑ hallucinations
	❑ suicidal thoughts	❑ memory changes	❑ difficulty sleeping
HEMATOLOGY	❑ easy bruising	❑ prolonged bleeding	❑ enlarged lymph nodes
ALLERGIC-IMMUNOLOGIC	❑ sinus allergy symptoms	❑ allergic dermatitis	❑ frequent illness
OTHER CURRENT SYMPTOMS:			

Name: _____ DOB: _____

MEDICAL HISTORY

Have you ever been treated for cancer? ☐ Yes ☐ No
If yes, what type of cancer? _____
Diagnosis Date: _____
Treatment Received: _____

Please check the appropriate boxes if you have a **HISTORY** of any of the following conditions:

√	Year	√	Year	√	Year
❑ Diabetes- Type 1 ❑ Diabetes – Type 2		❑ Pulmonary Embolus (PE) or Deep Vein Thrombosis (DVT)		❑ Thyroid Disease	
❑ High Blood Pressure		❑ Depression or Anxiety		❑ Autoimmune Disorder	
❑ Coronary Artery Disease		❑ Stomach Ulcer or Reflux		❑ Anemia	
❑ History of Heart Attack		❑ Skin disease		❑ HIV or AIDS	
❑ Tuberculosis		❑ Nerve Disorder		❑ History of Organ Transplant	
❑ Asthma		❑ Stroke		❑ History of Herpes Zoster	
❑ Pneumonia or Emphysema		❑ Seizures or Epilepsy		❑ Compromised Immune System	

Do you currently have or have had a history of the following (please circle): VRE MRSA C-DIFF Other: _____

CURRENT MEDICATION LIST

Please list all current medications in the list below. Dietary supplements should be included in Nutrition History.

Name of Medication	Dosage	Frequency

Do you take Aspirin or any other non-steroidal anti-inflammatories (NSAIDS- i.e., Ibuprofen, Motrin, Plavix, Lovenox)? ☐ Yes ☐ No
Please list all NSAIDs below.

Have you ever been a patient at the Northside Hospital Pain Clinic? ☐ Yes ☐ No

Have you ever received narcotics for pain management? ☐ Yes ☐ No
*If yes, please list any **current** pain meds below, along with medical prescriber.*

Name: _____ DOB: _____

SURGICAL HISTORY		
Have you ever had any anesthesia complications? ☐ Yes ☐ No		
If yes, describe the type of anesthesia complications:		
Type of Surgery	**Date of Surgery**	**Complications**

FAMILY MEDICAL HISTORY			
Please list your biological family medical history below. If family history unknown, due to adoption, please check ☐			
Relationship	**Alive / Deceased**	**Health Issues (Diagnosis)**	**Age when health issue or diagnosis occurred**
Biological Mother			
Biological Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			
Aunt(s)			
Uncle(s)			