

Charlene Hickson, M.D.

Pueblo Ear, Nose and Throat Specialist
1218 Pueblo Blvd. Way, Pueblo, CO 81005
719-566-1277 (FAX 719-566-1257)

General Health Questionnaire

Patient Name: _____ Date: _____

Each of the following items is important in helping us find out about the illness that has brought you to see us.

Please answer each question as completely and as accurately as you can.

If you are unsure about a question, please ask one of the medical staff to clarify it.

Please briefly describe your health problems: _____

How long have you had this problem? (Approximate date of onset) _____

What is the name of the doctor who referred you to us? _____

If you have a primary care physician who is not the referring physician, please provide us with his/her name:

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

- | | | | |
|----------------------------------|-------------------|------------------------|-----------------------|
| High blood pressure | Heart attack | Abnormal heart rhythm | Heart failure |
| Heart murmur | Seizures | Stroke | Syncope/fainting |
| Kidney disease | Hepatitis | Liver disease/jaundice | Thyroid problems |
| Pneumonia | Tuberculosis (TB) | Arthritis | Acid reflux/heartburn |
| Diabetes | Asthma | Blood transfusion | Bleeding problems |
| Cancer | Skin cancer | Radiation treatment | Substance abuse |
| Blood clots/deep vein thrombosis | | High cholesterol | Migraine headaches |

Other conditions you have been treated for:

Please list *all* past surgeries:

When?	What was done?
_____	_____
_____	_____
_____	_____
_____	_____

Please turn over

Allergies to medications: _____

_____ Check here if you have no known drug allergies

_____ Any Iodine Allergy

_____ Any Latex Allergy

_____ Any Adhesive Allergy

Medications (please include non-prescription medications, such as aspirin, herbal treatments, and vitamins that you take on a regular basis):

Medication

Reason for taking

Review of Symptoms: Please circle all symptoms which you have had *over the last month*:

General:	Fatigue	Chills	Muscle aches	Night sweats	Weight loss/gain
Eyes:	Change in vision		Double vision		
Ears:	Hearing loss	Ringings	Dizziness	Vertigo	Ear pressure Ear pain
Nose:	Nasal congestion		Nasal bleeding	Nasal drainage	
Throat:	Difficulty swallowing		Change in voice		
Lungs:	Shortness of breath		Frequent cough		Wheezing
Cardiovascular:	Chest pain		Irregular heart beat		Ankle swelling
Gastrointestinal:	Heartburn	Nausea/vomiting	Diarrhea		Constipation
Genitourinary:	Difficulty urinating		Blood in urine		
Neurological:	Depression	Memory loss	Weakness	Numbness	Tingling

Occupation: _____

Previous occupation if retired: _____

Do you currently smoke? _____ Yes _____ No Packs/Day _____ Years _____

Have you smoked in the past? _____ Yes _____ No Packs/Day _____ Years _____

Do you drink alcohol? _____ Yes _____ No How much? _____

Have you had problems with alcohol in the past? _____ Yes _____ No

Do you currently use drugs? _____ Yes _____ No

Have you had problems with drugs in the past? _____ Yes _____ No

Do you have any HIV/AIDS risk factors? _____ Yes _____ No

Do you have any blood relatives who have had any of the following conditions? (Please circle all that apply):

Heart disease	Problems with Anesthesia	Diabetes	Hearing Loss
High Blood Pressure	Bleeding problems	Asthma	
Stroke	Cancer	Allergies	