BECKER
EAR, NOSE & THROAT CENTER

Robbinsville/Hamilton: 609-436-5740
Princeton: 609-430-9200
Sewell: 856-589-6673
Voorhees: 856-772-1617

General Health Questionnaire

Patient Name _____ Date _____

Medications:

Are you taking any medication, drugs or pills ☐ Yes ☐ No If yes, please list name and dosage. _____

_____

Allergies:

Do you have any allergic or adverse reactions to any medication or substance ☐ Yes ☐ No If yes, please list _____

_____

Hospitalizations:

Have you been admitted in the hospital during the past five years? ☐ Yes ☐ No
If yes, please list name of hospital and year of admission _____

_____

Past Medical History:

Please check if you suffer from or have been treated for any of the following medical conditions
☐ Hypertension ☐ Diabetes ☐ Arthritis ☐ Stroke

☐ Other _____

Past Surgical History:

Please list any major surgeries you have had and the year _____

_____

Family History:

Please check if any of the following diseases run in your family and indicate which relative(s) (father, mother, brother, sister):
☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Heart Problem

☐ Bleeding Tendencies ☐ Other _____

Social History:

Do you smoke? ☐ Yes ☐ No If yes, # of packs _____ per day/week.
Do you drink alcohol? ☐ Yes ☐ No If yes, # of glasses _____ per day/week.
Do you use any street drugs? ☐ Yes ☐ No If yes, what type? _____ .

Patient's Name _____

I understand the above information is necessary to provide me with health care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you/ I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature _____ Date _____
I have reviewed all information in the health survey and discussed it with the patient/guardian.

Audiologist Signature _____ Date _____