Bancroft O'Quinn, Jr., M.D.
1405 Baddour Parkway, Suite 106
Lebanon, TN 37087

Referring Physician: _____

Name: _____ Age: _____

HISTORY QUESTIONNAIRE:
Do you have problems with the following?

☐Yes ☐No Nose Bleeding If yes, when? _____
☐Yes ☐No Drainage down the back of throat
☐Yes ☐No Frequent Sore Throat
☐Yes ☐No Frequent Hoarseness
☐Yes ☐No Frequent Dry Coughing
☐Yes ☐No Frequent Productive Coughing
☐Yes ☐No Frequent Headaches If yes, how often? _____
Do your headaches cause: ☐Nausea ☐Vomiting ☐Sensitivity to Light or Sound ☐Visual Disturbance
Are your headaches usually: ☐Mild ☐Moderate ☐Severe
How many years have you had frequent headaches?: _____
☐Yes ☐No Frequently Runny Nose
☐Yes ☐No Frequent Sneezing
☐Yes ☐No Frequently Itchy Nose
☐Yes ☐No Frequently Congested Nose
☐Yes ☐No Frequent Throat Clearing
☐Yes ☐No Frequently Itchy Eyes
☐Yes ☐No Frequently Watery Eyes
☐Yes ☐No Frequently Red Eyes
☐Yes ☐No Frequently Swollen Eyes
☐Yes ☐No Hearing Loss If yes, ☐ R ☐L Since when? _____
Recent hearing test? ☐Yes ☐No
When and where: _____ Results: ☐Normal ☐Abnormal
☐Yes ☐No Exposure to loud noise?
☐Yes ☐No Ear Pain
Does chewing worsen ear pain? ☐Yes ☐No
Frequent gum-chewing ☐Yes ☐No
Bruxism (Grind or Grit Teeth?) ☐Yes ☐No
☐Yes ☐No Ear Drainage If yes, ☐R ☐L
☐Yes ☐No Ear Fullness If yes, ☐R ☐L
☐Yes ☐No Ringing in Ears If yes, ☐R ☐L
Frequent Caffeine (coffee, tea, colas, chocolate) intake? ☐Yes ☐No
Frequent aspirin/ibuprofen intake? ☐Yes ☐No
☐Yes ☐No Imbalance
☐Yes ☐No Spinning Dizziness
Any trauma to head prior to dizziness? ☐Yes ☐No
☐Yes ☐No Difficulty Swallowing
☐Yes ☐No Pain Swallowing
☐Yes ☐No Chocking Sensation
☐Yes ☐No Frequent Heartburn
☐Yes ☐No Wheezing
☐Yes ☐No Snoring
☐Yes ☐No Thirst upon Awakening
☐Yes ☐No Mouth breathing or difficulty breathing through your nose?
☐Yes ☐No Frequent Tonsillitis If yes, how many episodes during the last 12 months? _____
☐Yes ☐No Daytime Sleepiness
☐Yes ☐No Heart fluttering
☐Yes ☐No Restless nighttime sleep
☐Yes ☐No Have you ever had trauma to your nose? If yes, when? _____

_____Initial _____Date

☐Yes ☐No Thunderous snoring
☐Yes ☐No Breath holding for more that 15 seconds during sleep?
☐Yes ☐No Have you ever had a sleep study?
☐Yes ☐No Are your allergy/sinus/hayfever symptoms year round?
☐Yes ☐No Are your allergy/sinus/hayfever symptoms seasonal?
If seasonal, which seasons are worse? _____
☐Yes ☐No Have you ever been tested for allergies? When? _____ Where? _____
☐Yes ☐No Do you have animals in the house? If yes, cats _____, dogs _____, other _____
☐Yes ☐No Do you often use over the counter allergy medicine?
☐Yes ☐No Do you frequently use over the counter nasal sprays?
☐Yes ☐No Do you use a feather pillow or down comforter?
☐Yes ☐No Are there stuffed animals on your bed or in your bedroom?
☐Yes ☐No Do you use a humidifier?
☐Yes ☐No Do you eat or drink dairy products often?
☐Yes ☐No Do you frequently use scented soaps, deodorants, cologne, perfume, etc?

Do you have a history of:

Diabetes	☐Yes	☐No	Heart Disease	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Cancer	☐Yes	☐No	Hepatitis	☐Yes	☐No	Mental Disease	☐Yes	☐No
Anemia	☐Yes	☐No	Glaucoma	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Asthma	☐Yes	☐No	Arthritis	☐Yes	☐No	Free Bleeding	☐Yes	☐No
Stroke	☐Yes	☐No	Any Communicable Disease (HIV, AIDS, etc)			☐Yes	☐No	

☐Yes ☐No Do you have any family history of hearing loss?
Which relative(s)? _____
☐Yes ☐No Do you have a family history of Diabetes?
Which relative(s)? _____

List medicines you are allergic to: _____

List medicines you are currently taking: _____
_____
_____
_____

List all hospitalizations and operations: _____
_____
_____
_____

☐Yes ☐No Are you a cigarette smoker? If yes, number of packs per day: _____ # of years _____

When did you quit smoking? _____

Reason for visiting the doctor today: _____
_____
_____
_____
_____