Oregon Health & Science University
Hospitals and Clinics
Otolaryngology Clinic

OC4501

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

HEAD AND NECK SURGERY PATIENT QUESTIONNAIRE

Today's Date:_____ Referring Doctor: _____ Age: _____

Preferred Contact Phone#: _____ Home ZIP code**:** _____

Reason for today's visit: _____

Date 1st Noticed: _____ Prior Tests (list): _____

Location: _____ Prior Treatments (list): _____

Please check below if you have any of the following:

☐ Neck Mass ☐ Mouth Ulcer ☐ Change in Vision ☐ Face Numbness (1 side)
☐ Ear Pain ☐ Mouth Bleeding ☐ Change in Voice ☐ Watery Eye (1 side)
☐ Difficulty Swallowing ☐ Nose Bleeding ☐ Coughing Blood ☐ Plugged Nose (1 side)
☐ Pain with Swallowing ☐ Noisy Breathing ☐ Fevers/Chills/Sweats ☐ Other: _____
☐ Difficulty opening Jaw ☐ Difficulty Breathing ☐ Face Weakness (1 side)
☐ Weight Loss (if yes, how much? _____

Please check the appropriate boxes below: (risk factors for head and neck cancer)
Do you smoke cigarettes?

☐ Yes [Current] Start date: _____ Average # packs/day: _____
☐ No [Quit] Start date: _____ Quit Date: _____ Average # packs/day: _____
☐ No [Never] (<100 lifetime cigarettes)

Have you ever used any other forms of tobacco (pipes, cigars, chewing tobacco) regularly?
☐ Yes ☐ No (if yes, please list which types used): _____

_____

Do you drink alcohol? *One drink includes 1 glass of wine, 1 beer, 1 mixed drink or 1 shot of liquor.*

☐ Yes [Current] Start Date _____ Drink of choice: _____ Average # drinks/day: _____
☐ No [Quit] Start Date _____ Quit Date: _____ Average# drinks/day: _____
☐ No [Never] (<100 lifetime drinks)

Have you ever been exposed to radiation or Agent Orange? ☐ Yes ☐ No
Have any of your relatives ever had cancer? ☐ Yes ☐ No (if yes, please describe which relative(s) and what type of cancer) _____

_____

Have you ever used the following drugs regularly? (at lease once a month for a year)

Marijuana:	☐ Yes [Current]	☐ No [Quit]	☐ No [Never]
Cocaine:	☐ Yes [Current]	☐ No [Quit]	☐ No [Never]
Methamphetamine:	☐ Yes [Current]	☐ No [Quit]	☐ No [Never]

Please list your current medications: (including over the counter medications) _____

_____

_____

Please list any drug reactions or allergies: _____

Please list all prior surgeries: _____

_____

- Continued on reverse -

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Please check the appropriate boxes below regarding special medical conditions:

Have you ever had a heart attack? ☐ Yes ☐ No (if yes, when): _____

Have you ever been treated for heart failure (or taken a "water pill" for leg swelling or fluid in lungs)?
☐Yes ☐ No

Have you ever had an operation to unclog or bypass arteries in your legs? ☐ Yes ☐ No

Have you ever had a stroke (blood clot or bleeding in the brain)?
☐ Yes ☐ No (if yes, when:_____ any difficulty moving an arm or leg): ☐ Yes ☐ No

Have you ever had a transplant? ☐ Yes ☐ No (if yes, when:_____ which organ): _____

Do you have emphysema, chronic obstructive lung disease or chronic bronchitis? ☐ Yes ☐ No

Do you have stomach ulcers or peptic ulcer disease? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No
(if yes, please list any problems with your eyes or kidneys caused by diabetes) _____

Do you have any kidney disease requiring dialysis? ☐ Yes ☐ No

Do you have leukemia or lymphoma? ☐ Yes ☐ No (if yes, please describe): _____

Do you have cancer other than skin cancer, leukemia or lymphoma? ☐ Yes ☐ No (if yes, please describe):
_____

Do you have cirrhosis or other severe liver disease? ☐ Yes ☐ No (if yes, please describe): _____

Do you have Alzheimer's or any other form of dementia? ☐ Yes ☐ No (if yes, please describe): _____

_____

Please check the boxes below for other medical conditions you have or have had:

☐ High Blood Pressure	☐ HIV/AIDS	☐ Hepatitis	☐ Glaucoma
☐ High Cholesterol	☐ Bleeding Disorder	☐ Asthma	☐ Seizures
☐ Atrial Fibrillation	☐ Anemia	☐ Tuberculosis	☐ Arthritis
☐ Acid Reflux Disease	☐ Prostate Enlargement	☐ Cancer	☐ Other: _____

Do you have any of the following other symptoms now?

☐ Cough	☐ Vomiting	☐ Hives	☐ Constipation
☐ Chest Pain/Pressure	☐ Nausea	☐ Dizziness	☐ Difficulty Urinating
☐ Leg/Ankle Swelling	☐ Jaundice	☐ Hearing Loss	☐ Other: _____

Other Confidential Information:

What city do you currently live in? _____

Current Residence: ☐ Home/Apartment ☐ Independent Living Center ☐ Care Facility ☐ Other

Who lives with you? _____

Employment: ☐ Retired ☐ Working Currently ☐ Unemployed ☐ Other
(if working or previously employed, please describe your occupation(s): _____

Level of Activity: ☐ Exercise ☐ Active, no Exercise ☐ Active with Assist Only ☐ Not Active

Walking: ☐ No difficulty ☐ With Cane or Assist ☐ Wheelchair ☐ Other

The above questionnaire has been reviewed by me. Corrections and additions have been added as needed.

Doctor Signature:_____ Date:_____

☐ NA SITE: ☐ Oral Cavity ☐ Oropharynx ☐ Hypopharynx / cervical esophagus ☐ Larynx
☐ Hypopharynx ☐ Nasopharynx ☐ Paranasal sinuses ☐ Skin ☐ Salivary ☐ Thyroid

PATH: ☐ SCC ☐ PTC ☐ Other: _____

RECURRENT: ☐ Yes ☐ No

STAGE: ☐ Clinical ☐ Pathologic T_____ N _____ M _____

ZUBROD STATUS: ☐ 0(KPS 90-100) ☐ 1(70-80) ☐ 2(50-60) ☐ 3(30-40) ☐ 4(10-20)