



JAMES J. LEE, M.D., F.A.C.S.
JOHN Y. CHEW, M.D. F.A.C.S.

NORTHERN ORANGE COUNTY ENT MEDICAL CORP

100 E. Valencia Mesa Dr. Suite 111, Fullerton, CA 92835 Tel: 714-441-0133
2675 W. Olympic Blvd, Suite 202, Los Angeles, CA 90006 Tel: 213-736-1884

DIPLOMATE AMERICAN BOARD
OF OTOLARYNGOLOGY

OTORHINOLARYNGOLOGY
OTOLOGY

Patient Health Questionnaire

Name (Nombre): _____ Date (Fecha): _____ Sex: F M

Date of Birth: _____ Family Doctor: _____
(Fecha de Nacimiento) (Doctor Familiar)

General Health: Excellent (Excelente) Good (Buena) Fair (Mala) Poor (Pobre)
(Su salud en General)

Please circle the answer that applies to you: (Por favor circule la respuesta que aplica a usted)

Yes (Si) No 1. Do you have high blood pressure? (Tiene Ud. alta presion de la sangre?)

Yes (Si) No 2. Do you have any heart condition/ailment or history of stroke?
If yes, please specify: _____
(Tiene Ud. condicion del corazon or historia de paro cardiaco? Si contesto si, por favor explique)

Yes (Si) No 3. Do you have diabetes? (Tiene Ud. Diabetes?)

Yes (Si) No 4. Do you have thyroid or goiter problem? (Tiene Ud. problema de la tiroides?)

Yes (Si) No 5. Do you have asthma, tuberculosis, bronchitis or any other lung problem?
(Tiene Ud asma, tuberculosis, bronquitis u otro problema de los pulmones?)

Yes (Si) No 6. Are you suffering of any seizures, convulsions, blackouts, fainting spells?
Please circle the answer that applies.
(Tiene Ud. ataques or covulciones, desmayos, mareos? Por favor circule)

Yes (Si) No 7. Do you have kidney, prostate, bladder or any other urinary problem?
(Tiene Ud. problema del rinon, prostata, vejiga, u otro problema urinario?)

Yes (Si) No 8. Do you smoke? If so, how many packs a day? _____
(Usted fuma? Cuantos paquetes al dia?)

If not, have you smoked in the past? (Ud. fumaba en el pasado? _____
How many packs per day? (Cuantos paquetes al dia?) _____
How long did you smoke? (Por cuanto tiempo fumo?) _____

Yes (Si) No 9. Do you have ulcers, gall bladder or stomach problem?
(Tiene Ud. problemas de ulceras, vesicular biliar o estomago?
Please Specify (Por favor especifique) _____

- Yes (Si) No **10. Are you pregnant or could you be possibly pregnant?**
(Esta Ud. embarazada o posiblemente puede estar embarazada?)
- Yes (Si) No **11. Are you presently being treated for any medical condition? If so, please state condition and treating doctor:** _____
(Tiene Ud. tratamiento por alguna condicion medica en este momento? Explique)
- Yes (Si) No **12. Do you have a history of cancer? If so, what type?** _____
(Tiene historia de Cancer? Que tipo?)
- Yes (Si) No **13. Do you have glaucoma, cataracts or any other eye diseases?**
(Tiene Ud. alguna enfermedad de los ojos? Glaucoma, cataratas?)
- Yes (Si) No **14. Do you drink alcohol? If so, do you drink daily, socially or rarely?**
(Toma Ud. alcohol? Cuanto? Diario, Socialmente, Rara la vez?)
- Yes (Si) No **15. Have you ever had Blood transfusion or Hepatitis?**
(Ha tenido transfusion de sangre o Hepatitis?)
- Yes (Si) No **16. Are you HIV positive? (Es UD. portador del VIH/ SIDA?)**
- Yes (Si) No **17. Are you presently taking any medications? Please list medications.**
(Esta tomando along medicamento? Por favor anote el nombre)

- Yes (Si) No **18. Do you have any allergies to medications? Please state medication(s).**
(Tiene Ud. alergia a algun medicamento? Por favor anote el nombre)

- Yes (Si) No **19. List all previous surgeries and hospitalizations:**
(Por favor anote el nombre de cirugias u hospitalizaciones anteriores)

Thank you for taking the time to answer the health questionnaire. Please hand questionnaire to the receptionist. (Gracias por tomar el tiempo para contestar este cuestionario)

Patient Name: _____ DOB: _____