UCLA Health

MRN:
Patient Name:

(Patient Label)

PATIENT QUESTIONNAIRE- REVIEW OF SYSTEMS
DEPARTMENT OF HEAD AND NECK SURGERY

YES	NO	
☐	☐	Have you had recent unexplained weight loss?
☐	☐	**Have you had change in your vision?**
☐	☐	Have you had difficulty swallowing?
☐	☐	**Have you had strokes or seizures?**
☐	☐	Have you had chest pain at rest or with activity?
☐	☐	**Have you had shortness of breath or wheezing?**
☐	☐	Have you had stomach ulcers or passing blood?
☐	☐	**Have you had frequent urinary tract infections?**
☐	☐	Have you had joint aches or muscle pain?
☐	☐	**Have you had skin rashes?**
☐	☐	Have you had easy bruising?
☐	☐	**Have you had treatment for depression or anxiety?**
☐	☐	Have you had an inability to tolerate cold?
☐	☐	**Have you had an allergic reaction causing throat swelling?**
☐	☐	Have you ever had an angioplasty?
☐	☐	**Have you ever had a heart stent placed?**
☐	☐	Have you ever had a cardiac stress test?
☐	☐	**Have you ever been seen by a cardiologist or heart specialist?**
☐	☐	Do you have a bleeding disorder or prolonged bleeding?
☐	☐	**Do you take blood thinners?** *(examples: Plavix, Coumadin, Pradaxa, Aspirin)*
☐	☐	Have you had any complications with anesthesia?
☐	☐	**Do you have a family member who had complications with anesthesia?**
☐	☐	Do you have any dentures, bridges or veneers?
☐	☐	**Do you have any limitations or pain when moving your neck?**
☐	☐	Do you have a history of sleep apnea (OSA)?
☐	☐	**Have you ever been told you have severe snoring or gasp while sleeping?**

***Patient Certification*:**
To the best of my knowledge, the questions on this form have been accurately answered.
I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient or Representative Signature ____________________________ Date ________ Time _______

If signed by someone other than the patient, please specify relationship to the patient: ____________

Interpreter Signature __________________________ ID # _______ Date ________ Time ________

Physician Signature ___________________________ ID # _______ Date ________ Time ________