

Patient: \_\_\_\_\_ Health Evaluation Questionnaire

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D M Y

We would appreciate your assistance in completing this confidential health evaluation form. The information obtained from you will allow us to assess more accurately the nature of your problem. Where several symptoms are mentioned, please underline or circle those that apply to you.

	Past	Present	Never	Office Use Only		
Do you notice a burning sensation on your tongue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you notice any impairment of your sense of taste?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Is swallowing difficult for you at times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have occasional difficulties with speech?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you smoke and if so, how many per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have earaches? Left side / Right side / Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you notice a buzzing, ringing or whooshing noise in your ears? Frequently / Occasionally / Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you notice a loss of hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you notice increased sensitivity to noise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you notice fullness, stuffiness or itching of the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you ever feel a loss of balance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you ever feel dizzy or nauseous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you ever "black out" temporarily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you experience deep pain behind the eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have a stiff neck or shoulders? Frequently / Occasionally / Rarely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have upper or lower back problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have tingling or numbness in the hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have joint pains elsewhere in the body? Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

