SOUTHWEST OHIO ENT SPECIALISTS, INC.

Patient Health Questionnaire

In order for us to obtain medical information, it is very important for you to fill out this form as completely as possible. ***Please fill out every item.***

Patient's Last Name: ________________________________ First: __________________________ MI: ____

Date of Birth: ___________________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

1) Have you ever had radiation for cancer? Yes or No

2) Have you ever had chemotherapy? Yes or No

3) Have you ever had a colonoscopy? Yes or No

   If Yes, Approximate date of procedure? _______________________