Dr. Denis Grillo
790 SE 5th Terrace, Crystal River, FL 34429

PATIENT NAME: _____ DATE: _____

Please check which symptom you are having:

□ **HOARSENESS GREATER THAN 2-3 WEEKS** □ **CHRONIC COUGH GREATER THAN 8 WEEKS**
□ **TROUBLE SWALLOWING /CHOKING** □ **LUMP IN THROAT**

1. **DURATION:** □ **Days** □ **Weeks** □ **Months** □ _____
   a. **TIMING :** □ **CONSTANT** □ **EPISODES**
2. **PRIOR HISTORY:** □ **Yes** □ **No**
3. **TOBACCO USE:** □ **Yes** □ **No**
4. **ALCOHOL USE:** □ **Yes** □ **No**
5. **HISTORY THYROID:** □ **Yes** □ **No** □ **FAMILY**
6. **HISTORY RADIATION HEAD/NECK:** □ **Yes** □ **No**
7. **ANY HIGH FEVERS:** □ **Yes** □ **No**
8. **SUDDEN/ UNEXPLAINED WEIGHT LOSS:** □ **Yes** □ **No**
9. **HEARTBURN (REFLUX):** □ **Yes** □ **No**
10. **ASPIRATION (CHOKING/STICKING) FOOD:** □ **Yes** □ **No**
11. **SWALLOWING DIFFICULTY:** □ **Yes** □ **No**

Please circle any that apply:

12. **VOICE USE(I.E. SINGING) – ABUSE(I.E. YELLING) – VOICE CHANGES – HOARSE**
13. **HISTORY SURGERY Head/Neck: THROAT – INTUBATION – INJURY – INFECTION**
14. **ALLERGIES – ASTHMA – INHALERS – BRONCHITIS – POST NASAL DRIP**
15. **GENERALIZED WEAKNESS – HEART DISEASE – ANEURYSMS**
16. **COUGH (COUGHING BLOOD) – TUBERCULOSIS – CANCER**
17. **THROAT PAIN – EAR PAIN** □ **LEFT** □ **RIGHT**
18. **CHEST PAIN – HEART PRESCRIPTION**
19. **BREATHING DIFFICULTY / NOISY BREATHING**
20. **CHEST X-RAY – SINUS X-RAY- CT SCANS – MRI**

_____ _____
Patient Signature Date