Sore throat/strep throat/pharyngitis/tonsillitis

QUESTIONNAIRE

****PLEASE USE BLUE OR BLACK INK ONLY****

Patient's name:_____

DOB:_____ **DATE:**_____

1. How frequently did you experience an episode of tonsillitis/pharyngitis/strep throat/sore throat?

In the past year?
- ☐ Two or less
- ☐ Three or four
- ☐ Five or more

In previous years?
- ☐ Two or less
- ☐ Three or four
- ☐ Five or more

2. Did you see a physician to establish the diagnosis on each occasion?
- ☐ **Yes** ☐ **No**

3. Were cultures of your throat obtained at the time of your diagnosis?
- ☐ **Yes** ☐ **No**

4. On the average, how many days of work/school were missed by you?

Each episode
- ☐ 3 or less
- ☐ 3 to 5 days
- ☐ 7 to 14 days

Total for the year
- ☐ 5 days or less
- ☐ 1 to 2 weeks
- ☐ 2 to 3 weeks

5. Were you treated with antibiotics for your condition when the diagnosis was made?
- ☐ **Yes** ☐ **No**

With each episode?
- ☐ **Yes** ☐ **No**

6. Did you experience fever with your condition?
- ☐ **Yes** ☐ **No**

7. Do you experience "bad breath" (halitosis)?
- ☐ **Yes** ☐ **No**

8. Do you experience swallowing problems?
- ☐ **Yes** ☐ **No**

Lump in Throat, Cough, Hoarseness, and Dysphagia Questionnaire

QUESTIONNAIRE

****PLEASE USE BLUE OR BLACK INK ONLY****

Patient Name: _____

DOB: _____DATE: _____

Yes	No	
_____	_____	Heartburn
_____	_____	Indigestion
_____	_____	Burping
_____	_____	Reflux
_____	_____	Use of antacids/medications for acid
_____	_____	Bad taste in mouth
_____	_____	Smoking
_____	_____	Cough
_____	_____	Difficulty swallowing
_____	_____	Lump in throat
_____	_____	Throat clearing
_____	_____	Hoarseness
_____	_____	Irritated throat/sore throat
_____	_____	Post nasal drainage
_____	_____	Congestion
_____	_____	Sneezing
_____	_____	Runny nose/nasal drainage
_____	_____	Allergy medications/allergy work up