Western Washington Medical Group
Ear, Nose & Throat
Allergy & Audiology

# Medical History Questionnaire



**Patient Name:**_____ **Date:**_____

**Date of Birth:**_____

**Reason for today's visit?** _____

**When did you first notice the problem?** _____

**Have you been treated for or used anything for this problem?** _____

_____

## Please list any current medical problems:

| | | |
|---|---|---|
| | | |
| | | |
| | | |

## Please list any prior major illness and/or injuries:

| | | |
|---|---|---|
| | | |
| | | |

## Please list any surgeries or hospitalizations:

| *Operation/Reason for hospitalization* | *Year* | *Hospital Name* | *Problems/Complications?* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Family Medical History:** Does any member of your family have cancer, diabetes, heart disease, respiratory disease or other illnesses? Please include deceased family members.

| *Relationship* | *Medical Condition(s)* |
|---|---|
| | |
| | |
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| | |

**Social History:** Circle your answer.

**Occupation:**_____

**Marital Status:** Single Married Divorced Widowed

**Do you have children?** Yes / No **How many?**_____

**Do you live alone?** Yes / No **Who lives with you?**_____

**For women:** Are you pregnant or considering conceiving? Yes / No

Are you taking birth control pills? Yes / No

**Review of Systems**: Are you currently or have you had problems with any of the following? All sections not circled will be consider as a "No" answer.

## *Please Circle Yes or No*

**Constitutional**

| | | |
|---|---|---|
| Fever | Yes | No |
| Night sweats | Yes | No |
| Decreased appetite | Yes | No |
| Weight Loss | Yes | No |

**Eyes**

| | | |
|---|---|---|
| Glasses | Yes | No |
| Glaucoma | Yes | No |
| Cataracts | Yes | No |

**Ear**

| | | |
|---|---|---|
| Hearing Loss | Yes | No |
| Ear ringing/tinnitus | Yes | No |
| Dizziness | Yes | No |
| Vertigo | Yes | No |
| Ear Infections | Yes | No |
| Ear drainage | Yes | No |

**Nose**

| | | |
|---|---|---|
| Nasal polyps | Yes | No |
| Problems with smell | Yes | No |
| Broken Nose | Yes | No |
| Nose Bleeds | Yes | No |
| Sinus Problems | Yes | No |

**Throat**

| | | |
|---|---|---|
| Sore Throat/Tonsillitis | Yes | No |
| Hoarse or irregular voice | Yes | No |
| Difficulty swallowing | Yes | No |
| Pain | Yes | No |
| Lump or bump | Yes | No |

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain or angina | Yes | No |
| High Blood Pressure | Yes | No |
| Irregular Heart Beat | Yes | No |
| High Cholesterol | Yes | No |
| Heart Valve | Yes | No |
| Swelling of hands/feet | Yes | No |

**Respiratory**

| | | |
|---|---|---|
| Asthma | Yes | No |
| Emphysema/Bronchitis | Yes | No |
| Shortness of Breath | Yes | No |
| Chronic Cough | Yes | No |
| Tuberculosis | Yes | No |
| Snoring | Yes | No |

**Gastrointestinal**

| | | |
|---|---|---|
| Nausea/Vomiting | Yes | No |
| Liver Disease/Hepatitis | Yes | No |
| Ulcers or Gastritis | Yes | No |
| Acid Reflux/Heartburn | Yes | No |

**Genitourinary**

| | | |
|---|---|---|
| Renal Failure | Yes | No |
| Prostate Cancer | Yes | No |
| Uterine/Cervical Cancer | Yes | No |

**Musculoskeletal**

| | | |
|---|---|---|
| Arm or Leg Weakness | Yes | No |
| Arthritis | Yes | No |
| Broken Bones | Yes | No |

**Integumentary**

| | | |
|---|---|---|
| Rash | Yes | No |
| Skin Disease | Yes | No |
| Nipple Discharge | Yes | No |

**Neurological**

| | | |
|---|---|---|
| Head Injury | Yes | No |
| Headache/Migraine | Yes | No |
| Seizures | Yes | No |
| Double or Blurry Vision | Yes | No |
| Facial Weakness | Yes | No |
| Stroke | Yes | No |

**Endocrine**

| | | |
|---|---|---|
| Diabetes | Yes | No |
| Thyroid Disease | Yes | No |
| Menopause | Yes | No |

**Hematologic**

| | | |
|---|---|---|
| Anemia | Yes | No |
| Bleeding Disorder | Yes | No |

**Psychiatric**

| | | |
|---|---|---|
| Anxiety | Yes | No |
| Depression | Yes | No |
| Panic Attacks | Yes | No |

**Allergies**

| | | |
|---|---|---|
| Food Allergies | Yes | No |
| Nasal/Hay fever | Yes | No |

## Risk Factors: (*Please circle or write your answers*.)

**Caffeine use:** (includes: coffee, soda, and caffeinated tea) Yes / No **Cups per day?** _____

**Do you wear your seatbelt?** (*circle a percentage*) 100% 75% 50% 25% 0%

**Sun Exposure:** Frequent Occasional Rare

**Does anyone smoke around you regularly?** Yes / No

**Tobacco Use (past or present):** Yes / No

**Year started?**_____ **Year quit?**_____ **Packs per day?**_____

**Do you chew tobacco:** Yes / No

**Drug Use (recreational):** Yes / No **Type?**_____

**Alcohol Use:** Yes / No **Type?**_____ **Amount:**_____

**Do you exercise?** Yes / No **Type:**_____ **Days per week:**_____

**Medications –** Include if you are taking Aspirin, Ibuprofen, or other blood thinners (ex. Plavix, Coumadin/warfarin)

| *Medication Name* | *Dose* | *Frequency* |
|---|---|---|
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**Drug Allergies**: (please write allergen drug names, if any, in the boxes below)

| | | |
|---|---|---|
| | | |
| | | |

*Do you have any interest in learning more about our cosmetic skin care products and services? Yes / No*

Thank you for taking the time to fill out this questionnaire!

I believe that the above information is correct to the best of my knowledge:

Patient Signature: _____ Date: _____

I have reviewed the above information with the patient.

Physician signature: _____ Date: _____