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? _____

_____

List Current & Past Medical Diagnosis:

List All Prior Surgeries:

Operation/Reason for Hospitalization	*Year*	*Hospital Location*	*Problems or Complications?*

List Biological Family Medical Histroy:

Relationship	*Maternal/Paternal*	*Medical Condition(s)*

Social History:

Occupation: _____

Marital Status: Single Married Divorced Widowed

Number of Children: _____

Do you live alone? Yes No

For Women:

Are you preganant or considering conceiving? Yes No

Are you taking birth control pills? Yes No

First day of your last menstrual cycle? _____

MEDICAL HISTORY QUESTIONNAIRE

Risk Factors:

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

What percent of the time do you wear a use a seatbelt: 100% 75% 50% 25% 0%

Sun Exposure: Frequent Occasional Rare

Does anyone smoke around you regularly? Yes / No

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

Year started: _____ Year quit: Packs per day: _____

Smokeless tobacco? Yes No

Use a vape? Yes No

Recreational Drug Us Yes No

Alcohol Use: Yes No Type: _____ Drinks a day: _____

Physcial Exercise: Yes No Type: _____ Days Per Week: _____

Medication: Include if you are taking any over the counter medications.

Medication Name	*Strength*	*How Often*

Are you taking Aspirin, Ibuprofen, or other blood thinners (ex. Plavix, Coumadin/warfarin)? Yes No

Drug Allergies:

Drug Name	*Reaction*

By signing below you acknowledge that the above information is true and correct to the best of your knowledge.

Patient Signature: _____

Printed Name: _____