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? _____

ALLERGY - REVIEW OF SYSTEMS

Review of Systems: Are you currently or have you had probems with any of the following?

Please Check: Yes or No

*All sections not checked will be considered as a "No" answer.

ALLERGY		
Food Allergies	Yes	No
Inhalant/Seasonal Allergies	Yes	No
Bee Sting Allergy	Yes	No
Metal Allergy	Yes	No
Penicillin/ Antibiotic Allergy	Yes	No
Contact Dermatitis	Yes	No
Hay Fever	Yes	No
Anaphylaxis	Yes	No

GENERAL		
Fever	Yes	No
Chills	Yes	No
Sweats	Yes	No
Anorexia	Yes	No
Fatigue/Weakness	Yes	No
Malaise	Yes	No
Weight Loss	Yes	No
Sleep Disorder	Yes	No
Recent weight gain	Yes	No

EYES		
Swelling	Yes	No
Itching	Yes	No
Redness	Yes	No
Watery	Yes	No
Pain	Yes	No

ENT		
Itching	Yes	No
Fullness/Plugged	Yes	No
Dizziness/Vertigo	Yes	No
Pain	Yes	No
Nasal Polyps	Yes	No
Epistaxis	Yes	No
Congestion	Yes	No
Runny Nose	Yes	No
Loss of smell	Yes	No
Post Nasal Drip	Yes	No
Dryness/Scabbing	Yes	No
Difficulty Swallowing	Yes	No
Jaw/Upper Teeth Pain	Yes	No
Hoarseness	Yes	No
Sore Throat	Yes	No
Dry Cough	Yes	No
Hearing Loss	Yes	No
Drainage	Yes	No
Tinnitus/Ringing	Yes	No

CARDIOVASCULAR		
Chest Pain	Yes	No
Hypertension	Yes	No
Irregular Heartbeat	Yes	No
High Cholesterol	Yes	No
Swelling of hands and feet	Yes	No
Taking Beta Blocker	Yes	No

RESPIRATORY		
Asthma	Yes	No
COPD	Yes	No
Shortness of Breath	Yes	No
Chronic Cough	Yes	No
Productive Cough	Yes	No
TB	Yes	No
Snoring	Yes	No
Chest pain w/ Deep Breath	Yes	No
Coughing Up Blood	Yes	No
Wheezing	Yes	No

GASTROINTESTINAL		
Abdominal Bloating/Pain	Yes	No
Bloody Stools	Yes	No
Change in bowel habits	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Hemorrhoids	Yes	No
Indigestion	Yes	No
Nausea	Yes	No
Pain with swallowing	Yes	No
Vomiting	Yes	No
Hx of Hepatitis A	Yes	No
Hx of Hepatitis B	Yes	No
Hx of Hepatitis C	Yes	No

INTEGUMENTARY		
Dry Skin	Yes	No
Itching	Yes	No
Non healing sores	Yes	No
Rash	Yes	No
Suspicious Lesions	Yes	No
Hives/ Urticaria	Yes	No
Angioedema	Yes	No

MUSCULOSKELETAL		
Neck Pain	Yes	No
Back Pain	Yes	No
Joint Pain	Yes	No
Joint Swelling	Yes	No
Muscle Weakness	Yes	No
General Weakness	Yes	No
Difficulty Swallowing	Yes	No

NEUROLOGICAL		
Head Injury	Yes	No
Chronic Headaches	Yes	No
Migraines	Yes	No
Seizures	Yes	No
Double/Blurry Vision	Yes	No
Facial Weakness	Yes	No
Tremors	Yes	No
Stroke	Yes	No

PSYCHIATRIC		
Anxiety	Yes	No
Depression	Yes	No
Panic Attacks	Yes	No
Insomnia	Yes	No

ENDOCRINE		
Diabetes: Type I	Yes	No
Diabetes: Type II	Yes	No
Thyroid Disease	Yes	No
Menopause/ Pre Menopause	Yes	No

HEMATOLOGIC		
Anemia	Yes	No
Bleeding Disorders	Yes	No
Blood Thinners	Yes	No
	Yes	No

GENITOURINARY		
Renal Failure	Yes	No
Kidney Problems	Yes	No
Blood in Urine	Yes	No
Cervical Cancer	Yes	No

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: _____