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? ____________________

ENT - 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.

GENERAL		
Fever	Yes	No
Night Sweats	Yes	No
Decreased Appetite	Yes	No
Weight Loss	Yes	No

EYE		
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
Pain	Yes	No
Lump or Bump	Yes	No

CARDIOVASCULAR		
Chest Pain or Angina	Yes	No
High Blood Pressure	Yes	No
Irregular Heartbeat	Yes	No
High Cholesterol	Yes	No
Heart Valve	Yes	No
Swelling of Hands and Feet	Yes	No

RESPIRATORY		
Asthma	Yes	No
Emphysema/Bronchitis	Yes	No
Shortness of Breath	Yes	No
Chronic Cough	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/Migraines	Yes	No
Seizures	Yes	No
Double/Blurry Vision	Yes	No
Facial Weakness	Yes	No
Stroke	Yes	No

HEMATOLOGIC		
Anemia	Yes	No
Bleeding Disorders	Yes	No

PSYCHIATRIC		
Anxiety	Yes	No
Depression	Yes	No
Panic Attacks	Yes	No

Allergy		
Food Allergies	Yes	No
Nasal/Hay Fever	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: ____