Western Washington Medical Group

Ear Nose & Throat, Allergy, and 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)*

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*

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: _____