PATIENT HISTORY QUESTIONNAIRE

Western Washington Medical Group

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY:
Do you smoke? ❑ Yes ❑ No If Yes, Have you ever smoked? ❑ Yes ❑ No Start: Quit: Packs Per Day:
Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how often?
Please indicate your marital status: ❑ Married. How Long? _____ ❑ Single ❑ Divorced/Separated ❑ Widowed. How Long? _____
Do you have any children? ❑ Yes ❑ No If yes, how many?

OCCUPATION: Please indicate below the type of work you have done, approximate number of years involved in each occupation.

FAMILY HISTORY: Please comment of health of relatives. (Are they living? Do they have any medical problems? If deceased, please write cause and age at time of death.)
Mother:
Father:
Brothers:
Sisters:

HOBBIES: Please list below any particular hobbies you pursue?

NOTICE: *We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us or compels us to do so.To see your record or get more information about it inquire at our front desk.*

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HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE-YEAR?

- PLEASE ANSWER ALL QUESTIONS AND CHECK NO OR YES -

CONSTITUTIONAL

Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Night sweats or chills	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Daytime drowsiness	☐ No	☐ Yes
Changes in sleep	☐ No	☐ Yes

EYES

Eye disease	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes

ENT

Sinus problems	☐ No	☐ Yes
Persistent hoarseness	☐ No	☐ Yes
Post-nasal drip	☐ No	☐ Yes
Runny nose	☐ No	☐ Yes
Seasonal allergies	☐ No	☐ Yes
Broken nose	☐ No	☐ Yes

CARDIOVASCULAR

Heart problems	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes
Swelling feet or ankles	☐ No	☐ Yes
Blood clots	☐ No	☐ Yes
Rheumatic fever	☐ No	☐ Yes

RESPIRATORY

Frequent cough	☐ No	☐ Yes
Sputum production	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes
History of tuberculosis	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite	☐ No	☐ Yes
Stomach ulcers	☐ No	☐ Yes
Gastric reflux / heartburn	☐ No	☐ Yes
Liver problems / hepatitis	☐ No	☐ Yes

GENITOURINARY

Burning or painful urination	☐ No	☐ Yes
Kidney problems	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Frequent urinary infections	☐ No	☐ Yes

MUSCULOSKELETAL

Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles	☐ No	☐ Yes
Difficulty walking	☐ No	☐ Yes

SKIN

Rash	☐ No	☐ Yes
Persistent itching	☐ No	☐ Yes

NEUROLOGICAL

Frequent headaches	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Stroke	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes

ENDOCRINE

Thyroid disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes

HEMATOLOIGIC/LYMPHATIC

Easily bruising or bleeding	☐ No	☐ Yes
Anemia	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

Medication allergies	☐ No	☐ Yes
Food allergies	☐ No	☐ Yes

Patient Signature: _____

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REASON FOR VISIT/CURRENT COMPLAINT

DR'S NOTES (DO NOT WRITE IN THIS SPACE)

Please list any medical problems and date they were diagnosed			
Medical Problems	Year	Previous Surgeries and Hospitalizations	Year

Please list all current medications (may provide a separate list):					
Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please list any medications you are allergic to and what happens when you take them.