Northwest Ear Institute

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following questionnaire prior to your appointment with the physician. The information is very important to us for your care, so please answer all the sections as accurately as possible.

Name: _____ Age: _____ Birth Date: _____

Reason for Today's Visit: _____

Height: _____ Current Weight: _____

Date of Last:

Bone Density: _____ Pneumovax Immunization: _____

Flu Immunization: _____ Tetanus Immunization: _____ Colonoscopy: _____

For Women

Last Mammogram: _____ Last Menstrual Period: _____

Last Cervical Screening: _____ Age 65+: History of Urinary Incontinence: ☐ Y ☐ N

Past Medical History (Check any illnesses you have):

☐ High Blood Pressure	☐ Asthma/Emphysema	☐ Rheumatic Fever	☐ Diabetes
☐ Kidney Disease	☐ Stroke/Mini-Stroke	☐ Hepatitis	☐ Sinusitis
☐ Heart Disease	☐ Peptic Ulcers	☐ Thyroid Disease	☐ Seizures
☐ Neck/Back Disorder	☐ Poor Circulation	☐ Bleeding Problems	

☐ Cancer (Please list type and date of diagnosed): _____

☐ Others: _____

Past Surgical History (Check all that apply):

☐ Heart Bypass/Valve	☐ Gallbladder	☐ Prostate Removal	☐ Kidney Transplant
☐ Coronary Angioplasty	☐ Lung Surgery	☐ Colon Removal	☐ Neck Surgery
☐ Carotid Artery Surgery	☐ Joint Replacement	☐ Appendix Removal	☐ Brain Surgery
☐ Vascular Bypass	☐ Back Surgery	☐ Sinus Surgery	☐ Tonsil Removal
☐ Mastectomy/Breast Surgery	☐ Cancer Surgery (Type and date) _____		

☐ Other: _____

Name of Pharmacy: _____ Address: _____

Medications (List all current medications and the doses you take):

_____

_____

Do you take Aspirin/Ibuprofen? ☐ Y ☐ N

Do you take Warfarin (Coumadin)? ☐ Y ☐ N

Do you take an herbal medication? ☐ Y ☐ N

Have you taken steroids in the last year? ☐ Y ☐ N

Allergies (List medications/foods you are allergic to and your reaction to them): _____

_____

_____

Family History (Check all illnesses that run in your family):

☐ Hearing Loss	☐ Alcoholism	☐ Heart Disease	☐ High Blood Pressure
☐ Sickle Cell Anemia	☐ Psychiatric Illness	☐ Thyroid Disease	☐ Poor Circulation
☐ Bleeding Problems	☐ Diabetes	☐ Epilepsy	☐ Voice Problems
☐ Anesthesia Reaction	☐ Stroke		

☐ Cancer (Type): _____

Social History:

How many children do you have? _____

Have you ever smoked? ☐ Y ☐ N

If yes, what kind: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew ☐ Vaping/E-cigarette ☐ Marijuana

How much/how long have you used? _____ per day for _____ years

Do you ever drink alcohol? ☐ Y ☐ N *How often/how long?* _____

Do you ever drink caffeine? ☐ Y ☐ N *How often/how long?* _____

List any street/illegal drugs you currently or have used? _____

Review of Systems (Check all symptoms you have NOW)

Constitutional:

☐ Weight Loss ☐ Weight Gain ☐ Fever/Chills ☐ Fatigue

Eyes, Ears, Nose and Throat:

☐ Double Vision ☐ Hearing Loss ☐ Nose Bleeds ☐ Difficulty Swallowing ☐ Loss of Vision
☐ Ringing in Ears ☐ Nose Drainage ☐ Voice Change ☐ Eye Pain ☐ Dizziness
☐ Nasal Congestion ☐ Snoring ☐ Dry Eyes ☐ Ear Pain ☐ Facial Pain
☐ Hoarseness ☐ Toothaches ☐ Sore Mouth/Throat ☐ Neck Pain/Swelling

Cardiovascular/Pulmonary:

☐ Chest Pain ☐ Heart Attack ☐ Irregular Heartbeat ☐ Bronchitis ☐ Leg Pain
☐ Asthma/Wheezing ☐ Shortness of Breath ☐ Persistent Cough ☐ Coughing up Blood

Gastrointestinal:

☐ Stomach Ulcers ☐ Nausea/Vomiting ☐ Diarrhea ☐ Frequent Use of Antacid ☐ Heartburn
☐ Abdominal Pain ☐ Blood in Stool

Genitourinary:

☐ Blood in Urine ☐ Painful Urination ☐ Difficulty Urinating

Musculoskeletal:

☐ Neck/Back Pain ☐ Muscle Aches ☐ Arthritis

Skin:

☐ Skin Cancers ☐ Allergy to Tape, Iodine or Latex

Neurological:

☐ Stroke/Mini-Strokes ☐ Head Trauma ☐ Facial Paralysis ☐ Arm/Leg Paralysis ☐ Confusion
☐ Memory Loss ☐ Seizure ☐ Loss of Vision/Speech

Infectious Disease:

☐ Hepatitis ☐ HIV/AIDS ☐ Mononucleosis ☐ Shingles ☐ Tuberculosis

Psychiatric:

☐ Depression ☐ Schizophrenia ☐ Anxiety or Panic Attack ☐ Hallucinations

Over the past two weeks, how often have you been bothered by any of the following? *(Circle one)*	Not at All	Several Days	More than Half of Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3