NORTHWEST EAR INSTITUTE, PC

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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 the 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 (Circle 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 (Circle 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 (Circle 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? Yes___ No___

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 (Circle 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 Ring 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 Attach 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 2 weeks, how often have you been bothered by any of the following? (circle one)	**None at all**	**Several days**	**More than half of days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3