



Welcome!

Washington University Otolaryngology Medical History Form

Please complete all of this form and bring it with you to your office visit.

Patient's Name _____ Today's Date / /

Date of Birth / / Gender Male Female

Who referred you here? _____ Phone _____

Name of Your Primary Care Physician _____ Phone _____

Your Preferred Pharmacy and City _____ Phone _____

PRESENT CONDITION AND/OR REASON FOR THIS APPOINTMENT

Please list all medical complaints or symptoms that have caused you to seek medical attention today. Include how long you have had the problem(s).

COMPLAINT OR SYMPTOM	HOW LONG

Of the above listed complaints or symptoms, which is your chief medical complaint or most bothersome symptom?

MEDICAL HISTORY

Please check any medical problems you have had: I have none of the below listed conditions and no known illnesses.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies; seasonal/
environmental | <input type="checkbox"/> Cataracts/Glaucoma | <input type="checkbox"/> Hereditary Hemorrhagic
Telangiectasia (HHT) | <input type="checkbox"/> Recurrent urinary tract
infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Reflux disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression/Bipolar
disorder | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peptic or gastric ulcer | <input type="checkbox"/> Sinus Infection, recurrent |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> DVT/Blood clots | <input type="checkbox"/> Peripheral Vascular
Disease | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Bone fractures; which
bones _____ | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Recurrent/Chronic
bronchitis | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Heart disease (specify) _____ | <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> Other(s) not listed above (specify) _____ | | | |

HOSPITALIZATIONS

List reason for hospitalization and the year. Do not include surgeries. _____

None

SURGERIES

List all other surgeries, including plastic surgery and Lasik, and the year.

TYPE OF SURGERY	YEAR	TYPE OF SURGERY	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had problems with general anesthesia? No Yes If yes, specify reaction _____

MEDICINES

Do you take blood thinners? No Yes, specify name and dosage _____

List all Prescription Medicines you take. Include oral medications, nasal sprays/steroids, and topical ointments.

Medication Name	Dose (How much)	Frequency (How Often)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check all NON-Prescription Medicine you take.

- Aspirin _____ mg Advil/Motrin/Nuprin (Ibuprofen) Naproxen Tylenol (Acetaminophen)
 Vitamin E Multi-Vitamin Cold/Allergy _____
 Other Vitamins/Supplements (list) _____ Herbals (list) _____

ALLERGIES

ALLERGIES TO MEDICINE	REACTION	ENVIRONMENTAL ALLERGIES	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to latex? No Yes

FAMILY MEDICAL HISTORY

For your blood relatives, list medical conditions and their relationship to you. None

Serious Illnesses: _____

Cancer: _____

Other: _____

_____/_____/_____
Name Date of Birth

PERSONAL AND SOCIAL HISTORY

Household and Family

Marital Status (optional): Single Married Divorced Separated Widowed

Employment (Check all that apply):

Employed full-time Employed part-time Occupation _____
 Retired Disabled Unemployed Student Homemaker

Tobacco and Alcohol

Do you drink alcohol? No, never drank No, but did in the past Year Quit _____
 Yes (Check all that apply) Beer Wine Mixed Drinks Straight Liquor/Shots
How many drinks do you have in the average week? _____

Do you use tobacco? No, never No, but did in the past Year Quit _____
 Yes (Check all that apply) Cigarettes Cigars Chew Pipe
How many cigarettes / cigars per day? _____

Have you ever used illegal drugs? No Yes (Check all that apply) Cocaine Marijuana Other _____

REVIEW OF SYSTEMS

Please check all of the following conditions you have.

GENERAL HEALTH (Constitutional)

Unintentional weight loss or gain Fever/Chills Fatigue/Tiredness None

EYES

Vision changes (decreased acuity, blurry, blindness) Double vision Dry eyes Tearing/Discharge
 Eye pain Itching/Burning None

EARS, NOSE, MOUTH AND/OR THROAT

Hearing loss Nasal discharge or drainage "Stuffy" nose or congestion Other _____
 Itchy ears Nasal obstruction or blockage Mouth growth, ulcer None
 Ear pain Nosebleeds Pronunciation difficulty
 Feeling of fluid in ears Sneezing Dental, gum, or mouth pain
 Ear discharge or drainage Mass or lump in throat or neck Dental problems/Poorly fitting dentures
 Ringing/Buzzing sound in ears Difficulty swallowing Voice changes/Hoarseness
 Dizziness Drooling Facial weakness
 Mass or lump in nose Recurrent/Chronic sore throat Facial pain
 Loss of sense of smell Snoring TMJ problems
 Breathing difficulty

HEART, VEINS, AND/OR ARTERIES (CARDIOVASCULAR)

Chest pain/Angina Swelling or fluid in legs Other _____
 Leg pain with walking Varicose veins None
 Leg pain at rest Irregular heart beat

LUNGS (RESPIRATORY)

Shortness of breath Cough None
 Wheezing Other _____
 Coughing up blood _____

REVIEW OF SYSTEMS *continued*

STOMACH, INTESTINES, GALLBLADDER, OR LIVER (GASTROINTESTINAL)

- | | | | |
|---|---|---|-------------------------------|
| <input type="checkbox"/> Decrease in appetite | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Diarrhea or constipation | <input type="checkbox"/> None |
| <input type="checkbox"/> Heartburn or reflux | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in stool | _____ | |

BONES, JOINTS, MUSCLES (MUSCULOSKELETAL)

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Cramping | <input type="checkbox"/> Hip/knee problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Joint stiffness/pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Bone fractures | _____ |
| | <input type="checkbox"/> Back/spine problems | which bone(s): _____ | <input type="checkbox"/> None |
| | | _____ | |

SKIN (INTEGUMENTARY SYSTEM)

- | | | |
|--|--|-------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Recent baldness | <input type="checkbox"/> None |
| <input type="checkbox"/> History of cold sores | <input type="checkbox"/> Other _____ | |

BRAIN AND/OR NERVES (NEUROLOGICAL)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blackouts/Fainting | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Tremors | _____ |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> None |

PSYCHIATRIC

- | | | | |
|--|--|---|-------------------------------|
| <input type="checkbox"/> Insomnia (trouble sleeping) | <input type="checkbox"/> Feeling depressed | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> None |
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Cutting/Self-inflicted injuries | <input type="checkbox"/> Other _____ | _____ |

HORMONES (ENDOCRINE)

- | | | | |
|--|--|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Excessive thirst/hunger/urination | <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |
| <input type="checkbox"/> Excessive sweating | | _____ | |

WOMEN ONLY

Are you pregnant? No Yes

KIDNEYS, BLADDER, GENITALS (GENITOURINARY)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Difficulty passing urine | <input type="checkbox"/> Frequent urination | _____ |
| <input type="checkbox"/> Incontinence | | <input type="checkbox"/> None |

BLOOD (HEMATOLOGIC/LYMPHATIC)

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Problems with blood clots | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Bleeding too long (will not clot) | <input type="checkbox"/> Other _____ |
| | | | <input type="checkbox"/> None |

PHYSICIAN REVIEW WITH PATIENT

No Past Medical Conditions

Physician's Signature

Date