



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

HOSPITALIZATIONS

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

None

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Tear here and take this bottom part home with you so you can remember important things.

Please see other side ▶

THINGS TO REMEMBER TO ASK MY DOCTOR

1. What is my main problem? _____
2. What do I need to do? _____
3. Why is it important for me to do this? _____
4. When will I start to feel better? _____
5. Other notes _____

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: _____

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help.

We want you to live a healthier life.

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 _____
 Leg pain at rest Irregular heart beat None

LUNGS (RESPIRATORY)

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

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If you have had imaging performed at an outside facility we will contact the facility and ask that your scans be sent to us for review and/or we may ask you to hand carry the scans. If necessary, we will ask for a diagnostic confirmation by our Washington University Radiologist.

★★The charge for the review (diagnostic confirmation) of your scans will be billed to your insurance. Individual insurance plans may vary and coverage is not a guarantee and YOU MAY RECEIVE A BILL FOR THIS SERVICE. Contact your Plan Administrator for specific details.

REVIEW OF SYSTEMS *continued*

STOMACH, INTESTINES, GALLBLADDER, OR LIVER (GASTROINTESTINAL)

- Decrease in appetite
- Nausea or vomiting
- Diarrhea or constipation
- None
- Heartburn or reflux
- Food intolerance
- Other _____
- Indigestion
- Blood in stool
- _____

BONES, JOINTS, MUSCLES (MUSCULOSKELETAL)

- Muscle weakness/fatigue
- Cramping
- Hip/knee problems
- Other _____
- Joint stiffness/pain
- Neck pain
- Bone fractures
- None
- Back/spine problems
- which bone(s): _____
- _____

SKIN (INTEGUMENTARY SYSTEM)

- Rash
- Recent baldness
- None
- History of cold sores
- Other _____

BRAIN AND/OR NERVES (NEUROLOGICAL)

- Headaches
- Blackouts/Fainting
- Other _____
- Paralysis
- Tremors
- None
- Numbness or tingling
- Sleep problems

PSYCHIATRIC

- Insomnia (trouble sleeping)
- Feeling depressed
- Eating disorders
- None
- Feeling anxious
- Cutting/Self-inflicted injuries
- Other _____

HORMONES (ENDOCRINE)

- Heat/cold intolerance
- Excessive thirst/hunger/urination
- Other _____
- None
- Excessive sweating

WOMEN ONLY

Are you pregnant? No Yes

KIDNEYS, BLADDER, GENITALS (GENITOURINARY)

- Blood in urine
- Painful urination
- Other _____
- Difficulty passing urine
- Frequent urination
- None
- Incontinence

BLOOD (HEMATOLOGIC/LYMPHATIC)

- Problems with blood clots
- Easy bruising
- Bleeding too long (will not clot)
- Other _____
- None

PHYSICIAN REVIEW WITH PATIENT

No Past Medical Conditions

Physician's Signature

Date

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Your healthcare is very important to us.
Thank you for choosing us for your healthcare.