Washington University in St. Louis Physicians

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.

- ☐ Allergies; seasonal/ environmental
- ☐ Asthma
- ☐ Anxiety
- ☐ Autoimmune Disorder
- ☐ Bleeding disorder
- ☐ Bone fractures; which bones _____
- ☐ Cancer
- ☐ Cataracts/Glaucoma
- ☐ COPD/Emphysema
- ☐ Depression/Bipolar disorder
- ☐ Diabetes
- ☐ DVT/Blood clots
- ☐ Eating disorders
- ☐ Heart Attack/MI
- ☐ Hepatitis
- ☐ Hereditary Hemorrhagic Telangiectasia (HHT)
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Peptic or gastric ulcer
- ☐ Peripheral Vascular Disease
- ☐ Radiation therapy
- ☐ Recurrent/Chronic bronchitis
- ☐ Recurrent urinary tract infections
- ☐ Reflux disease
- ☐ Seizures/Epilepsy
- ☐ Sinus Infection, recurrent
- ☐ Stroke/TIA
- ☐ Thyroid problems
- ☐ Tuberculosis (TB)

☐ Heart disease (specify) _____

☐ Other(s) not listed above (specify) _____

_____

HOSPITALIZATIONS

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

_____

_____

_____

_____

☐ **None**

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 ☐ Eye pain ☐ Dry eyes ☐ Itching/Burning ☐ Tearing/Discharge ☐ None

EARS, NOSE, MOUTH AND/OR THROAT

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

HEART, VEINS, AND/OR ARTERIES (CARDIOVASCULAR)

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

LUNGS (RESPIRATORY)

☐ Shortness of breath
☐ Wheezing
☐ Coughing up blood
☐ Cough
☐ Other_____
_____
☐ None

Hand Washing is Important to Stop the Spread of Illness and Infection

Wash Your Hands After:

- **(and before!) Handling food or eating.**
- **Using the bathroom or changing diapers.**
- **Sneezing, coughing or blowing your nose.**
- **Touching a cut, open sore or wound.**
- **Playing outside.**
- **Playing with pets or cleaning up after them.**

REVIEW OF SYSTEMS *continued*

STOMACH, INTESTINES, GALLBLADDER, OR LIVER (GASTROINTESTINAL)

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

BONES, JOINTS, MUSCLES (MUSCULOSKELETAL)

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

SKIN (INTEGUMENTARY SYSTEM)

☐ Rash
☐ History of cold sores
☐ Recent baldness
☐ Other_____
☐ None

BRAIN AND/OR NERVES (NEUROLOGICAL)

☐ Headaches
☐ Paralysis
☐ Numbness or tingling
☐ Blackouts/Fainting
☐ Tremors
☐ Sleep problems
☐ Other_____
_____
☐ None

PSYCHIATRIC

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

HORMONES (ENDOCRINE)

☐ Heat/cold intolerance
☐ Excessive sweating
☐ Excessive thirst/hunger/urination
☐ Other_____
_____
☐ None

WOMEN ONLY

Are you pregnant? ☐ No ☐ Yes

KIDNEYS, BLADDER, GENITALS (GENITOURINARY)

☐ Blood in urine
☐ Difficulty passing urine
☐ Incontinence
☐ Painful urination
☐ Frequent urination
☐ Other_____
_____
☐ None

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

WUP OTO NPQ D NL (Rev 09/12)

Your healthcare is very important to us.

Thank you for choosing us for your healthcare.