Washington University School of Medicine
Department of Otolaryngology - Head and Neck Surgery
Confidential Patient Information

Patient Name: _____ **Today's Date:**_____/_____/_____
Date of Birth:_____/_____/_____ **Gender: Man Woman (please circle)**

1. What made you seek medical attention today? (check all that apply)

_____ **Illness**
_____ **Family Concerns**
_____ **Employment Opportunities**
_____ **Physician Concerns**
Name of Physician: _____
_____ **Insurance Reasons**
_____ **Abnormal Medical Tests**
_____ **EKG** _____ **Blood** _____ **Other**

2. Please list all medical complaints or symptoms that have caused you to seek medical attention today (if you have none, please write "none"):

_____
_____
_____

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

_____
_____
_____

4. MEDICATIONS:
Please list all medications that you are presently taking: (If more than 6, please list on back)

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

5. ALLERGIES:

Medications (please list) **Environment (example-dust, mold, animal dander)**

_____
_____
_____
_____

6. SURGERIES:

Type of Surgery **Year**

_____
_____
_____

Preferred Pharmacy:

Name: _____
Phone: _____
Address: _____

7. FAMILY MEDICAL HISTORY:

Serious Illnesses: _____
Cancer: _____
Other: _____

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8. Please check all of the following diseases, disorders, or conditions you may have. If none, please check N/A

CARDIAC
- ☐ Hypertension (high blood pressure)
- ☐ Heart murmur
- ☐ Angina (chest pain)
- ☐ Heart attack
- ☐ Rhythm problems
- ☐ Heart valve problem
- ☐ Other: _____
- ☐ N/A

RESPIRATORY (lungs)
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Other: _____
- ☐ N/A

GENITOURINARY (kidney, bladder, urethra)
- ☐ Kidney stones
- ☐ Recurrent urinary tract infections
- ☐ Enlarged prostate (men only)
- ☐ Other: _____
- ☐ N/A

GASTROINTESTINAL (stomach, intestines)
- ☐ Ulcer
- ☐ Colitis
- ☐ Gallstones
- ☐ Hernia (hiatal/inguinal)
- ☐ Hemorrhoids
- ☐ Cirrhosis of liver
- ☐ Hepatitis
- ☐ Other: _____
- ☐ N/A

VASCULAR (arteries/veins)
- ☐ Varicose veins
- ☐ Strokes
- ☐ Peripheral vascular disease
- ☐ Other: _____
- ☐ N/A

LOCOMOTOR
- ☐ Arthritis
- ☐ Spine/back disorders
- ☐ Hip/knee impairment
- ☐ Bone fractures
  - Which bone(s): _____
- ☐ Other: _____
- ☐ N/A

ENDOCRINE (Hormones)
- ☐ Diabetes
- ☐ Other: _____
- ☐ N/A

PSYCHIATRY
- ☐ Neurosis
- ☐ Depression
- ☐ Schizophrenia
- ☐ Other: _____
- ☐ N/A

IMMUNE SYSTEM PROBLEMS
- ☐ AIDS
- ☐ Other: _____
- ☐ N/A

MISCELLANEOUS
- ☐ Abnormal Bleeding
- ☐ Gout
- ☐ Obesity
- ☐ Alcoholism/drug abuse
- ☐ Lupus
- ☐ Other _____
- ☐ N/A

GYNECOLOGY (for women only)
- ☐ Fibroid tumor
- ☐ Pelvic inflammatory disease
- ☐ Other: _____
- ☐ N/A

CANCER

Please indicate site(s):

_____

NEUROLOGY (brain and nerves)
- ☐ Migraine headache
- ☐ Epilepsy
- ☐ Sleep or awake problems
- ☐ Other: _____
- ☐ N/A

EYE
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other: _____
- ☐ N/A

EAR, NOSE, AND THROAT
- ☐ Recurrent/chronic ear infection
- ☐ Recurrent/chronic sinus
- ☐ Recurrent/chronic sore throat
- ☐ Other: _____
- ☐ N/A

8. Do you smoke cigarettes, cigars or pipes? ☐ Yes ☐ No

If yes, how much do you smoke? _____

If no, have you ever smoked?

If yes, how long ago did you quit? ☐ Yes ☐ No

9. Do you drink alcohol? ☐ Yes ☐ No

10. For women only: Are you pregnant? ☐ Yes ☐ No

Physician Review with Patient:

_____ _____

Physician Signature Date