Ear, Nose & Throat
Associates of North Central Wisconsin
Allergy and Immunology

Medical History Questionnaire

Name:________________________________ **Age:**_____ **Date:**______

Current health concerns:

What questions would you like answered today? (some concerns may require a follow-up visit)

Medical History:

Are you being seen by doctors for any health problems? ………….. ❑ Yes ❑ No If yes, please list below: ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________	**Emergency room visits? ….** ❑ Yes ❑ No Asthma related? ………...❑ Yes ❑ No Please list each ER visit: ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________
Have you ever had surgery? ❑ Yes ❑ No If yes, please list below: ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________	**If child, birth history/pregnancy history:** Any complications…………. ❑ Yes ❑ No Full term?..............................❑ Yes ❑ No If no, how many weeks gestation?_____ Birth weight:________________ **Any problems with insect stings?** ❑ Yes ❑ No ❑ Never stung
Other hospitalizations …. ❑ Yes ❑ No If yes, please list below: ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________	**Allergies:** **Allergies to medications?** ❑ Yes ❑ No If yes, please give date and describe reaction. ____________________________ ______________________________________ ______________________________________

Medications:
Please list all prescriptions and non-prescription medications, including vitamins, herbals, with name, strength, and how often you take them. (Include inhalers too).

Medication	Strength (mg)	How Often	Since When

Immunizations: Date of last tetanus vaccine:____________ Date of last influenza (Flu) vaccine?__________ Have you ever had pneumonia vaccine? ❑ Yes ❑ No

Family History:

Please check if your parents, brothers, sisters or your children have had any of the following (indicate which family member):

Allergies?........................ ❑ Yes ❑ No
Asthma?.......................... ❑ Yes ❑ No
Recurrent infections?............. ❑ Yes ❑ No
Immune deficiencies?............. ❑ Yes ❑ No
Bleeding tendency?............. ❑ Yes ❑ No
Cancer?................................ ❑ Yes ❑ No
Diabetes?.............................. ❑ Yes ❑ No

Gastrointestinal disease (reflux/heartburn)?.............. ❑ Yes ❑ No
Heart disease?..................... ❑ Yes ❑ No
High blood pressure?............ ❑ Yes ❑ No
Lung disease?..................... ❑ Yes ❑ No
Nervous disease?................ ❑ Yes ❑ No
Stroke?................................... ❑ Yes ❑ No
Tuberculosis? .... ❑ Yes ❑ No
Other:________________________________
____

Social History/Environmental History:

What is your occupation?________________
Do you have symptoms at work? ❑ Yes ❑ No
Do you use tobacco?.................. ❑ Yes ❑ No
If yes, type and daily amount:____________
For how long?_________________________
If you quit tobacco, when did you quit?_____
How long did you use tobacco?__________
Are you exposed to second hand smoke? ❑ Yes ❑ No
If yes, type and amount:________________
Marital status? _____Number of children____

Do you live in: ❑ house (owned)
❑ apartment/rental
❑ other:__________________

How old is property (estimate)?____________
Please circle all that apply:
Heat: gas / electric / radiator / oil ❑ Yes ❑ No
Air conditioning: central / wall unit / none
Humidifier/dehumidifier.......... ❑ Yes ❑ No
Flooring: wood / carpet / tile / linoleum / rugs
Bedding: mattress / box spring / waterbed
Encasements used................ ❑ Yes ❑ No
Pillow: feather / non-feather
Pets: (If yes, list types):__________________
Basement?......................... ❑ Yes ❑ No
If yes, has it flooded before?... ❑ Yes ❑ No
Is there obvious mold?............ ❑ Yes ❑ No
Any problems with roaches?...... ❑ Yes ❑ No
Mice?........ ❑ Yes ❑ No

Personal Health Review

General:

How do you rate your overall health?

❑ Excellent ❑ Good ❑ Not very good ❑ Poor

A weight change of more than 10 lbs. in the last year?.................................... ❑ Yes ❑ No

Fatigue?.................................... ❑ Yes ❑ No

Fever or Chills?.......................... ❑ Yes ❑ No

Night Sweats?............................ ❑ Yes ❑ No

Comments:______________________________

____

Skin:

Rash or itching?.......................... ❑ Yes ❑ No

Hives or swelling?...................... ❑ Yes ❑ No

Eczema?.................................... ❑ Yes ❑ No

Comments:______________________________

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Head:

Headaches?................................ ❑ Yes ❑ No

Recent head trauma?.................. ❑ Yes ❑ No

Comments:______________________________

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Ears:

Itching?..................................... ❑ Yes ❑ No

Fullness/popping?....................... ❑ Yes ❑ No

Comments:______________________________

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Eyes:

Itching/burning?......................... ❑ Yes ❑ No

Tearing/discharge?...................... ❑ Yes ❑ No

Redness/swelling?....................... ❑ Yes ❑ No

Glasses/contacts?........................ ❑ Yes ❑ No

History of glaucoma/cataracts?... ❑ Yes ❑ No

Comments:______________________________

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Nose:

Itching/sneezing?........................ ❑ Yes ❑ No

Drainage?.................................. ❑ Yes ❑ No

Congestion?............................... ❑ Yes ❑ No

Mouth breathing/snoring?........... ❑ Yes ❑ No

Change in sense of smell?........... ❑ Yes ❑ No

Comments:______________________________

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Throat:

Itching/soreness?........................ ❑ Yes ❑ No

Post nasal drainage?................... ❑ Yes ❑ No

Throat clearing?.......................... ❑ Yes ❑ No

Bad breath?............................... ❑ Yes ❑ No

Thrush?..................................... ❑ Yes ❑ No

Hoarseness?............................... ❑ Yes ❑ No

Comments:______________________________

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Lungs/Chest:

Cough?...................................... ❑ Yes ❑ No

Wheezing?................................. ❑ Yes ❑ No

Shortness of breath?................... ❑ Yes ❑ No

Chest tightness?......................... ❑ Yes ❑ No

Breathing problems with Exercise?................................... ❑ Yes ❑ No

Breathing problems in presence of animals?................................ ❑ Yes ❑ No

Breathing problems in presence of smoke or odors?..................... ❑ Yes ❑ No

If yes, which animals?_______________

Do you wake up at night because of your breathing?.......... ❑ Yes ❑ No

If yes, how often?

_____ times a night / week / month (circle one)

Comments:______________________________

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Heart:

Chest pain?................................ ❑ Yes ❑ No

Skipped heart beats/palpitations?

Heart murmurs?.......................... ❑ Yes ❑ No

High blood pressure?.................. ❑ Yes ❑ No

History of heart attack or heart surgery?......................... ❑ Yes ❑ No

Comments:______________________________

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Gastrointestinal:

Nausea/vomiting?....................... ❑ Yes ❑ No

Diarrhea?.................................. ❑ Yes ❑ No

Heartburn/reflux?....................... ❑ Yes ❑ No

Abdominal pain?......................... ❑ Yes ❑ No

Comments:______________________________

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Urinary tract:
History of bladder infections?...... ❑ Yes ❑ No
Increased frequency of urination? ❑ Yes ❑ No
Comments:______________________________
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Reproduction (women only):
Currently pregnant?.................... ❑ Yes ❑ No
Planning on pregnancy?............. ❑ Yes ❑ No
Are you nursing?........................ ❑ Yes ❑ No
History of yeast infections?......... ❑ Yes ❑ No
Comments:______________________________
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Muscle and bone:
Painful/swollen joints?................ ❑ Yes ❑ No
Stiffness?................................... ❑ Yes ❑ No
Back pain?.................................. ❑ Yes ❑ No
History of arthritis?..................... ❑ Yes ❑ No
History of osteoporosis?............. ❑ Yes ❑ No
Comments:______________________________
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Nervous system and brain:
Weakness of arms or legs?.......... ❑ Yes ❑ No
Numbness of arms or legs?......... ❑ Yes ❑ No
Depression/anxiety?................... ❑ Yes ❑ No
Comments:______________________________
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Blood and metabolism:
Unusual hair growth or loss?...... ❑ Yes ❑ No
Heat or cold intolerance?............ ❑ Yes ❑ No
Easy bruising?........................... ❑ Yes ❑ No
Bleeding problems?.................... ❑ Yes ❑ No
History of diabetes?.................... ❑ Yes ❑ No
History of thyroid disease?.......... ❑ Yes ❑ No
History of anemia or leukemia?... ❑ Yes ❑ No
Comments:______________________________
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Immune system:
Have you (the patient) had any of the following?

Recurrent fevers?........................ ❑ Yes ❑ No
Frequent antibiotics?.................. ❑ Yes ❑ No
Need for intravenous antibiotics? ❑ Yes ❑ No
Ear infections?............................ ❑ Yes ❑ No
If yes, how many?____________
Pneumonia?................................ ❑ Yes ❑ No
If yes, how many?____________
Sinus infections?......................... ❑ Yes ❑ No
If yes, how many?____________
Thrush? (yeast infections)......... ❑ Yes ❑ No
Skin infections?........................... ❑ Yes ❑ No
Deep seated abscesses?.............. ❑ Yes ❑ No
Meningitis?................................ ❑ Yes ❑ No
Failure of infant to gain weight or grow normally?....................... ❑ Yes ❑ No
Family history of recurrent infections or primary immune deficiency?... ❑ Yes ❑ No
If yes, which relative?__________
Have you ever received a Pneumovax or Prevnar vaccination?.............. ❑ Yes ❑ No
Comments:______________________________
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<u>To be filled in by medical staff at visit</u>.
Reviewed with patient and/or family

By________________________________

Date______________________________

Comments:__________________________
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