IDAHO EAR CLINIC

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

| | | |
|---|---|---|
| **Name** *(Last, First, M.I.):* ☐ M ☐ F | | **DOB:** |
| **Date of visit:** | **Marital Status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed. | |
| **Previous or referring doctor:** | **Date of last physical exam:** | |

## PERSONAL HEALTH HISTORY

| **List any medical problems that other doctors have diagnosed** | | |
|---|---|---|
| | | |
| **Is this problem the result of an accident?** | ☐ Yes | ☐ No |

| **Surgeries** | | |
|---|---|---|
| Year | Reason | Hospital |
| | | |
| | | |
| | | |
| | | |

| **Other hospitalizations** | | |
|---|---|---|
| Year | Reason | Hospital |
| | | |
| | | |
| | | |
| | | |

| **LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS** | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Allergies to medications | |
|---|---|
| Name the Drug | Reaction You Had |
| | |
| | |
| | |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Diet** | Rank salt intake | ☐ Hi | ☐ Med | ☐ Low | | |
| | Rank fat intake | ☐ Hi | ☐ Med | ☐ Low | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | | |
| | # of cups/cans per day? | | | | | |
| **Alcohol** | Do you drink alcohol? | | | | ☐ Yes | ☐ No |
| | If yes, what kind? | | | | | |
| | How many drinks per week? | | | | | |
| **Tobacco** | Do you use tobacco? | | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks./day | | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | ☐ Or year quit | | | | |
| **Drugs** | Do you currently use recreational or street drugs? | | | | ☐ Yes | ☐ No |

## MENTAL HEALTH

| | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Do you feel depressed? | ☐ Yes | ☐ No |
| Do you panic when stressed? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Have you ever been to a counselor? | ☐ Yes | ☐ No |

## REVIEW OF SYSTEMS

| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. | | | | | | | |
|---|---|---|---|---|---|---|---|
| General | ☐ Chills | ☐ Sleepiness | Ears | ☐ Dizziness | ☐ Drainage | Nose | ☐ Bleeding | ☐ Facial pain |
| | ☐ Fevers | ☐ Sweats | | ☐ Fullness | ☐ Hearing loss | | ☐ Congestion | ☐ Clogged |
| | ☐ Weight gain | ☐ Weight loss | | ☐ Itching | ☐ Pain | | ☐ Runny nose | ☐ Cough |
| | ☐ Fatigue | ☐ Loss of appetite | | ☐ Ringing | ☐ Pressure | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Throat | ☐ Bad breath | ☐ Foreign body | Skin | ☐ Bleeding | ☐ Rash | Allergic | ☐ Hay fever | ☐ Itching |
| | ☐ Heartburn | ☐ Pain | | ☐ Dryness | ☐ Lesions | | ☐ Runny nose | ☐ Environmental |
| | ☐ Snoring | ☐ Soreness | | ☐ Scarring | ☐ Ulcers | | | |
| | ☐ Swallowing | ☐ Voice changes | | ☐ Itching | ☐ Growths | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Neurologic | ☐ Dizziness | ☐ Tingling | Eyes | ☐ Discharge | ☐ Itching | Neck | ☐ Lump/mass | ☐ Syncope |
| | ☐ Numbness | ☐ Tremors | | ☐ Pain | ☐ Blurriness | | ☐ Thyroid problem | ☐ Pain |
| | ☐ Seizures | ☐ Weakness | | | | | | |

| | | | |
|---|---|---|---|
| Respiratory | ☐ Asthma | ☐ Shortness of breath | Other pain/Discomfort: |
| | ☐ Cough | ☐ Coughing up blood | |
| | ☐ Wheezine | | |

| **PHARMACY INFORMATION** | |
|---|---|
| Name of Pharmacy: | Pharmacy phone #: |
| Pharmacy address: | |

_____ _____ _____

Patient or Parent/Guardian Name | Patient or Parent/Guardian Signature | Date