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:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	

REVIEW OF SYSTEMS							
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.							
General	☐ Fevers	☐ Fatigue	Ears	☐ Itching	☐ Hearing loss	Nose	☐ Obstruction	☐ Bleeding
	☐ Chills	☐ Sleep problems		☐ Pain	☐ Wax		☐ Congestion	☐ Runny nose
	☐ Sweats	☐ Malaise		☐ Fullness	☐ Ringing		☐ Post-nasal drip	☐ Cough
	☐ Anorexia	☐ Weight changes		☐ Pressure	☐ Drainage		☐ Headache	☐ Allergies
Throat	☐ Soreness	☐ Bad breath	Skin	☐ Rash	☐ Scaring	Allergic/ Immunologic	☐ Urticaria	☐ Persistent infections
	☐ Pain	☐ Snoring		☐ Itching	☐ Bleeding		☐ Hay fever	☐ HIV
	☐ Swallowing	☐ Heartburn		☐ Ulcers	☐ Dryness			
	☐ Voice change	☐ Foreign body		☐ Growths	☐ Suspicious lesions			
Neurologic	☐ Paralysis	☐ Syncope	Vestibular	☐ Vertigo	☐ Double vision	Eyes	☐ Pain	☐ Diplopia
	☐ Weakness	☐ Tremors		☐ Imbalance	☐ Dizziness		☐ Vision loss	☐ Irritation
	☐ Paresthesia	☐ Vertigo		☐ Falling			☐ Excessive tears	☐ Discharge
	☐ Seizures	☐ Tingling					☐ Blurriness	☐ Photophobia
Neck	☐ Lump	☐ Thyroid problem	Respiratory	☐ Cough	☐ Coughing up blood	☐ Other pain/discomfort:		
	☐ Mass	☐ Pain		☐ Dyspnea	☐ Wheezing			
				☐ Excessive sputum	☐ Asthma			

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

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

Diet	Rank salt intake	☐ High	☐ Medium	☐ 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 currently use tobacco?			☐ Yes	☐ No
	☐ Cigarettes. Packs/day:	☐ Chew. Dips/day:	☐ Cigar. #/day:	☐ Pipe. #/day:	
	☐ Quit	# of years you have used tobacco:			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No

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	

PHARMACY INFORMATION	
Name of Pharmacy:	Pharmacy phone #:
Pharmacy address:	