



Patient Name: _____

Reviewed: _____, M. D.

Date: _____

MEDICAL QUESTIONNAIRE

Patient Name: _____ Date: _____

Occupation: _____ If retired, previous occupation: _____

1. Reason for today's visit: _____

2. Please list your other physicians and their specialties:

3. How would you rate your general health? _____

4. Have you had any of the following? (Please circle):

- | | | |
|------------------------------|-------------------------|----------------------------------|
| Headache | Ulcers/Stomach Problems | Sinus/Nasal Disease |
| Stroke | Gallbladder Disease | Hoarseness/Voice Problems |
| Meningitis/Encephalitis | Bowel Irregularity | Difficulty Swallowing |
| Other Nervous System Disease | Hepatitis/Liver Disease | Facial Pain |
| Psychiatric Disorder | Kidney/Urinary Disease | Asthma/Lung Disease |
| Glaucoma/Eye Disease | Prostate Problems | Allergies/Hay Fever |
| Heart Disease | Thyroid Disease | Radiation Therapy |
| High Blood Pressure | Diabetes | Skin Problems |
| Fainting Spells | Arthritis/Gout | Autoimmune Disease (Lupus, etc.) |
| Peripheral Vascular Disease | Cancer/Tumors | Weight Loss |
| Anemia/Easy Bleeding | | |
| Muscle/Skeletal Problems | Other: _____ | |

5. As a child, did you have any of the following? (Please circle):

- | | |
|-------------|------------------------------|
| Measles | Ear Infections |
| Mumps | Other Significant Illnesses: |
| Chicken Pox | _____ |
| | _____ |

6. Previous operations (please list type and date):

- Ear: _____
- Neurosurgical: _____
- Other: _____
- Any difficulty with anesthesia? _____ Any bleeding problems after surgery? _____

(Continue on back)

Patient Name: _____

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7. Describe any previous injuries or accidents:

To the ear and head: _____

Other: _____

Noise Exposure: _____

8. List any diseases that run in your family history:

Ear: _____

Brain/Nervous System: _____

Bleeding Disorders: _____

Other: _____

9. Social habits::

Smoking? Packs daily _____ How long? _____ When did you stop? _____

Caffeine? (Coffee, tea, cola): _____

Alcohol? (Type/Amount): _____

Diet? Regular: _____ Special: _____

Exercise? Type: _____ How Often? _____

10. Are you disabled in any way? _____

Do you have any birth defects? _____

Have you had alternative medical care (acupuncture, chiropractic, naturopath, etc.)? _____

RECORD OF MEDICATIONS

A. Allergies to any medications? _____

Please list medication and what reaction was experienced: _____

B. Current medications (include aspirin, vitamins, over-the-counter medications, and ear drops):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

(Continue on separate page if necessary)

C. Have you taken Cortisone in the past year? _____ If yes, please explain usage: _____

D. Please list any hazardous chemicals you come into contact with at work: _____

E. Have you had any of the following:

1. Prolonged use of antibiotics given by vein (IV)? _____

2. Chemotherapy agents for cancer? _____

3. High doses of aspirin (more than 8 per day)? _____

4. Quinine for malaria? _____

5. Diuretics (water pills)? _____

If yes to any of the above, please explain:
