Wellstone HEALTH PARTNERS

PLACE PATIENT STICKER HERE

WELLSTONE EAR, NOSE & THROAT
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HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

What problem can we help with today? _____

Who is your regular doctor? _____ ❑ **No Primary Medical Doctor**

PAST MEDICAL HISTORY			
❑ **NO MEDICAL PROBLEMS**	❑ Other _____		
Problem	**Type/Comment**	**Problem**	**Type/Comment**
❑ Acid Reflux/GERD		❑ Hepatitis C	
❑ Anemia		❑ HIV	
❑ Asthma		❑ High Cholesterol	
❑ Bleeding Disorder		❑ High Blood Pressure	
❑ Cancer		❑ Liver Disease	
❑ COPD		❑ Migraines	
❑ Diabetes		❑ Sleep Apnea	
❑ Hayfever (Allergies)		❑ Renal Failure	
❑ Head Injury		❑ Thyroid Disease	
❑ Heart Disease		❑ Tuberculosis	

PAST SURGICAL HISTORY		
❑ **NO PREVIOUS SURGERIES**		
Year	**Type**	**Hospital/Doctor**

*Additional sheet for listing surgeries available at the front desk

FAMILY HISTORY		
❑ Allergies	❑ Cancer: _____	❑ Migraines
❑ Anesthesia problems	❑ Diabetes	❑ Seizures
❑ Asthma	❑ Hearing Loss (before 50)	❑ Stroke
❑ Bleeding Disorder	❑ Heart Disease	❑ Other:

PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, HERBALS, AND SUPPLEMENTS		
Medication Name	Strength	Frequency Taken

*Additional sheet for listing medications and/or allergies available at the front desk

MEDICATION AND FOOD ALLERGIES			
❑ **No Medication Allergies**		❑ Latex Allergy	❑ Iodine (Shellfish) Allergy
Medication/Food	Type of Reaction	Medication/Food	Type of Reaction

SOCIAL HISTORY		
Occupation	What do/did you do for work?	Are you retired? ❑ Yes ❑ No
Alcohol	Do you drink alcohol? ❑ Yes ❑ No	If yes, what kind(s)?
	How many per week?	Has anyone been concerned about your drinking? ❑ Yes ❑ No
Tobacco	Do/did you use tobacco? ❑ Yes ❑ No	Secondhand smoke exposure? ❑ Yes ❑ No
	Cigarettes – packs/day:	Number of years: Year quit:
Other	Do you currently use recreational or street drugs? ❑ Yes ❑ No	

CURRENT SYMPTOMS (PLEASE CIRCLE) OR ❑ NO SYMPTOMS			
Constitutional/General	Difficulty Swallowing	Nausea	**Endocrine**
Fatigue	Snoring	Vomiting	Heat Intolerance
Fevers	Sore Throat	**Genitourinary**	Cold Intolerance
Night Sweats	Hoarseness	Frequent Urination	**Psychological**
Weight Loss	Sores/Ulcers In Mouth	Genital Ulcers	Anxiety
Weight Gain	Neck Swelling/Lump	**Skin**	Panic Attacks
Eyes	**Cardiovascular**	Itchy Skin	Depression
Double Vision	Chest Pain	Ulcers	Suicidal Thoughts
Dry Eyes	Blacking Out / Fainting	Rash	**Hematological/Lymphatic**
Vision Change	Swelling Of Ankles/Feet	**Neurological**	Easy Bleeding
Ear, Nose, Mouth, Throat	**Respiratory**	Headache	Bruising
Hearing Loss	Cough	Seizures	Heavy Periods (if female)
Ear Infections	Shortness of Breath	Falling	**Allergic/Immunological**
Dizziness	Wheezing	Numbness	Eczema
Ear Pain	**Gastrointestinal**	Weakness	Itchy Eyes
Ringing /Noise In Ears	Constipation	**Musculoskeletal**	Runny Nose
Nasal Congestion	Diarrhea	Jaw Popping / Grinding	Sneezing
Nose Bleeds	Heartburn	Neck Pain or Injury	Urticaria / Hives

Office Use Only

Reviewed by MD: _____ Date: _____