Ear, Nose and Throat Medical Group of Washington, P.C.
New Patient/Annual Questionnaire

Example:
headache ● yes O no

Please do not use X's or lines. Your answers will be read incorrectly.

Patient Name: _____

PAST MEDICAL HISTORY: (Please select any that apply)

coronary artery disease	O yes	kidney disease	O yes
arrhythmia (irregular heart beat)	O yes	hernia	O yes
hypertension (high blood pressure)	O yes	arthritis	O yes
hypercholesterolemia (high cholesterol)	O yes	osteoporosis	O yes
stroke	O yes	neurological disorders	O yes
asthma	O yes	migraine headache	O yes
COPD or emphysema	O yes	ADHD	O yes
environmental allergies/hay fever	O yes	developmental delay	O yes
sleep apnea	O yes	seizures	O yes
GERD (acid reflux)	O yes	anxiety disorder	O yes
hiatal hernia	O yes	depression	O yes
diabetes	O yes	anemia	O yes
thyroid disease	O yes	cancer	O yes
hepatitis	O yes	BPH(enlarged prostate)	O yes
HIV/AIDS	O yes	low back pain	O yes
tuberculosis	O yes	other_____	O yes

SOCIAL HISTORY:

alcohol:	O yes	O no
smoking:	O yes	O no
recreational drug use:	O yes	O no
caffeine:	O yes	O no
daycare (pediatric pts only):	O yes	O no
pets:	O yes	O no

FAMILY HISTORY:

cancer	O yes
coronary artery disease	O yes
diabetes	O yes
hearing loss	O yes
hypertension	O yes
liver disease	O yes

REVIEW OF SYSTEMS: (Mark all that apply at the PRESENT time. Please mark NO for those that don't apply.)

CONSTITUTIONAL

fever	O yes	O no
fatigue	O yes	O no
weight loss	O yes	O no

OPHTHALMOLOGY

diminished vision	O yes	O no

ENT

recent cold	O yes	O no
hearing loss	O yes	O no

CARDIOLOGY

chest pain	O yes	O no
palpitations	O yes	O no

RESPIRATORY

shortness of breath	O yes	O no
cough	O yes	O no
recent bronchitis	O yes	O no

GASTROENTEROLOGY

diarrhea	O yes	O no
vomiting	O yes	O no
heartburn	O yes	O no

NEUROLOGY

headache	O yes	O no
dizziness	O yes	O no

HEMATOLOGY/LYMPH

swollen glands	O yes	O no
easy bruising	O yes	O no

UROLOGY

difficulty urinating	O yes	O no

PSYCHOLOGY

depression	O yes	O no
anxiety	O yes	O no
sleep disturbance	O yes	O no