Mid-Columbia Ear, Nose & Throat, P.L.L.C.
Patient Profile

Name: _____ Today's Date: _____

Date of Birth: _____ ☐ Male ☐ Female Race: _____

Drug Allergies

Allergy	Reactions

Current Medications List prescription, over-the-counter, and herbal meds

Name of Medication	Dose and number of times take per day

Past Medical History

Do you or have you had:	Yes	No	If "yes", please describe
Abdominal problems			(i.e., ulcers)
Allergies			If so, to what and what was the reaction?
Have you required allergy shots?			
Arthritis			
Bleeding disorders			
Cancer			
Contagious disease			
AIDS			
Hepatitis			A B C
Tuberculosis			
Venereal disease			
Diabetes			
Eye disease			(ie, glaucoma)
Head or facial injuries			
Hearing loss			
Heart problems			
Heart attack			
High blood pressure			
Kidney problems			
Liver problems			(ie, cirrhosis)
Lung problems			(ie, asthma, emphysema)
Neurologic problems			(ie, seizures)
Psychiatric problems			
Stroke			
Thyroid problems			
Urologic problems			(ie, prostate, urinary)

Please list any other medical problems: _____

_____

Are you immunizations up to date? ☐ yes ☐ no If no, explain: _____

Mid-Columbia Ear, Nose & Throat, P.L.L.C.
Patient Profile (continued)

Name: _____ Today's Date: _____

Prior Surgeries

Type of surgery	Approximate date

Prior Hospitalizations

Reason	Approximate date

Family History

	yes	no	Relationship (mom, dad, grandparent, sibling, etc.)	maternal	paternal
Cancer (and type if known)					
Hearing loss					
Anesthesia problems					
Bleeding problems					
Lymphoma					
Leukemia					

Social History

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor Child
Family members in household: Children _____ Others: _____
Smoking: Packs per day _____ and for how long? _____
Chewing tobacco: How much _____ and for how long? _____
Smokers in the household? Yes____ No____
Alcohol use: Type_____ how much _____ and for how long? _____
Recreational or I.V. drug use: What type? _____ and for how long? _____
Pets in the house? Yes ____ No____ Type(s): _____

Are you currently experiencing any of the following?

Fever	☐	Sore throat	☐	Localized weakness	☐		
Chills	☐	Difficulty swallowing	☐	Seizures	☐		
Night sweats	☐	Neck pain	☐	Bleeding problems	☐		
Rashes	☐	Neck or swelling	☐		☐		
Blurred vision	☐	Shortness of breath	☐	Unusual fatigue	☐		
Eye pain	☐	Chest pain	☐	Recent weight loss	☐		
	☐		☐	How much?			
Decreased hearing	☐	Abdominal pain	☐	Over how long?			
	☐	Heartburn	☐				
Ear pain	☐	Reflux of acid	☐	Recent weight gain	☐		
Ear drainage	☐		☐	How much?			
Nose bleeding	☐	Trouble urinating	☐	over how long?			
Nose congestion	☐	Joint pain	☐				

Additional Information: Please list any further information or details from the questionnaire here: _____

_____