The Ear, Nose & Throat Center
at The GW Medical Faculty Associates

Medical Faculty Associates
Division of Otolaryngology
The George Washington University

GW Comprehensive Hearing Center
General Health Questionnaire

MRN: _____

Name _____ Date of birth_____

Occupation _____

Reason for visit _____

Duration of problem_____

Referring Physician name, address, phone, fax_____

_____

Preferred pharmacy name and address: _____

Phone #: _____ **fax #:** _____

Medications / vitamins /herbal supplements with dose and instructions:

1.	5.
2.	6.
3.	7.
4.	8.

Illnesses for which you take medications or have been hospitalized (reflux, high blood pressure, diabetes):

1.	5.
2.	6.
3.	7.
4.	8.

Operations / procedures you have had, in order from most recent and dates:

1.	5.
2.	6.
3.	7.
4.	8.

Allergies to medicines, foods, or environmental factors and types of reaction

_____

_____

Do you or did you ever **smoke**? Yes☐ No☐ Packs per day ____ How many years? _____
If you quit, when? _____

Do you drink **alcoholic beverages**? Yes☐ No☐ Amount _____

Are you **pregnant** or nursing? Yes☐ No☐ N/A☐

Do you or any blood relatives have a **bleeding problem** with surgery or cuts? Yes☐ No☐

Do you take aspirin, ibuprofen, herbal medication, or similar **blood thinners**? Yes☐ No☐

Medical problems that run in the **family** (diabetes, high blood pressure, high cholesterol):

Continue on the other side please

MEDICAL/SURGICAL HISTORY (check all that apply)

- ☐ Weight loss of 20 lbs. or more
- ☐ Fever / chills /night sweats
- ☐ Peripheral vascular disease
- ☐ Shortness of breath
- ☐ Cough / coughing blood
- ☐ Lung disease
- ☐ COPD / emphysema
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Double / Blurred vision
- ☐ Heartburn / reflux
- ☐ Stomach ulcers
- ☐ Urinary tract infections
- ☐ Problems passing urine
- ☐ Vaginal infection
- ☐ Pregnancy
- ☐ Anemia
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ History of trauma / assault
- ☐ Wounds
- ☐ Fracture
- ☐ Paralysis / stroke
- ☐ Seizures
- ☐ Muscle weakness / disease
- ☐ Numbness/tingling of hands or feet
- ☐ Psychological problems
- ☐ Anxiety
- ☐ Depression
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Angina or chest pain
- ☐ Thyroid Disease
- ☐ Rash
- ☐ Bruises
- ☐ Skin breakdown
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Nosebleed
- ☐ Sinus drainage
- ☐ Sinus congestion
- ☐ Sores (mouth, throat, neck)
- ☐ Hoarseness / voice change
- ☐ Lumps (mouth, throat, neck)
- ☐ Vertigo/balance problem
- ☐ Headache

Other medical problems, please list: _____

_____

Is there any other information you think we should know? _____

_____

_____