Maria M. Doucet, M.D.
4630 Ambassador Caffery Parkway
Bldg., A, Suite 402, Lafayette, LA 70508
Phone (337) 989-4453

Medical History Intake Questionnaire

Patient Name _____ Age_____ Date_____

Reason for Visit _____

_____

Past Medical History (Check all medical problems, past or present)

❑ Acoustic Neuroma	❑ Alcoholism	❑ Anemia	❑ Arthritis	❑ Asthma
❑ Cancer (Type)	❑ Cholesteatoma	❑ Congenital Infections	❑ Defects - Head/Neck	❑ Diabetes
❑ Emphysema	❑ Glaucoma	❑ Hay Fever	❑ Hearing Loss	❑ Heart Disease
❑ Hemophilia	❑ High Blood Pressure	❑ High Cholesterol	❑ Jaundice	❑ Kidney Disease
❑ Liver Disease	❑ Low Apgar Score	❑ Low Birth Weight	❑ Méniére's Disease	❑ Mental Illness
❑ Migraine	❑ Neurological Disorder	❑ NICU	❑ Noise Exposure	❑ Osteoporosis
❑ Otitis Media	❑ Otosclerosis	❑ Ototoxic Medications	❑ Perforated Ear Drum	❑ Premature
❑ Problems with Anesthesia		❑ Prolonged Mechanical Ventilation		❑ Seizures
❑ Stroke	❑ Syndrome _____		❑ Thyroid Disease	❑ Vertigo ❑ None

_____ _____

_____ _____

_____ _____

Surgeries (List all surgeries or if none, write none)

_____

_____

_____

_____

_____

Medications (Current medications or "as needed")

_____

_____

_____

_____

_____

Family History (Check all that apply to any blood relative)

❑ Acoustic Neuroma	❑ Alcoholism	❑ Anemia	❑ Arthritis	❑ Asthma
❑ Cancer (Type)	❑ Cholesteatoma	❑ Congenital Infections	❑ Defects - Head/Neck	❑ Diabetes
❑ Emphysema	❑ Glaucoma	❑ Hay Fever	❑ Hearing Loss	❑ Heart Disease
❑ Hemophilia	❑ High Blood Pressure	❑ High Cholesterol	❑ Jaundice	❑ Kidney Disease
❑ Liver Disease	❑ Low Apgar Score	❑ Low Birth Weight	❑ Méniére's Disease	❑ Mental Illness
❑ Migraine	❑ Neurological Disorder	❑ NICU	❑ Noise Exposure	❑ Osteoporosis
❑ Otitis Media	❑ Otosclerosis	❑ Ototoxic Medications	❑ Perforated Ear Drum	❑ Premature
❑ Problems with Anesthesia		❑ Prolonged Mechanical Ventilation		❑ Seizures
❑ Stroke	❑ Syndrome _____		❑ Thyroid Disease	❑ Vertigo ❑ None

Allergies to Medications (If you do not have any known allergies, write N/A)

_____ _____

_____ _____

SOCIAL HISTORY: (If you do not use or take – write N/A)

Tobacco: _____ packs/day x _____ years

Alcohol: _____ drinks/day x _____ years

Caffeine: _____ cups/day(coffee, tea, cola, etc)

OCCUPATION: _____
(Child, Secretary, Nurse, Engineer, Student, Etc.)

Quit _____ years ago

Heavy use in past? ❑ Yes ❑ No

Reviewed: _____

Continued on Next Page

Patient Name _____ DOB:_____ Date_____

REVIEW OF SYSTEMS:
Please answer yes or no to ALL of the following symptoms on the list. If yes, please check current if this symptom pertains to today's visit.

	No	Yes	Current		No	Yes	Current
bleeding problems	❑	❑	❑	chest pain	❑	❑	❑
constipation	❑	❑	❑	coughing	❑	❑	❑
diarrhea	❑	❑	❑	dizziness	❑	❑	❑
ear drainage	❑	❑	❑	eye pain	❑	❑	❑
fever	❑	❑	❑	frequent urination	❑	❑	❑
headache	❑	❑	❑	hearing loss	❑	❑	❑
hoarseness	❑	❑	❑	hot/cold flashes	❑	❑	❑
hypersensitivity of loud sounds	❑	❑	❑	joint aches	❑	❑	❑
				Itchy eyes	❑	❑	❑
mental health problems	❑	❑	❑	learning disorder	❑	❑	❑
muscle aches	❑	❑	❑	nasal congestion	❑	❑	❑
night sweats	❑	❑	❑	painful urination	❑	❑	❑
ringing in ears	❑	❑	❑	→ If yes, which ear is worse Left	or	Right	
shortness of breath	❑	❑	❑	sneezing	❑	❑	❑
throat pain	❑	❑	❑	weight loss	❑	❑	❑
speech or language delay	❑	❑	❑			Reviewed: _____	

Year 2016

---

1. Is the condition or symptoms for which you are seeking medical treatment related to or the result of an accident or incident? ❑Yes ❑No
   If so, please describe _____

   _____

2. Have you hired or consulted with an attorney about the condition, symptoms, accident or incident? ❑Yes ❑No

3. Have you or an attorney filed a claim with your employer or any other third party's insurance company, or filed a lawsuit relating to the condition, symptoms, accident or incident? ❑Yes ❑No

   If not, are you considering doing so? ❑Yes ❑No

Medical History:

Reviewed & Date: _____	Reviewed & Date: _____	Reviewed & Date: _____
Reviewed & Date: _____	Reviewed & Date: _____	Reviewed & Date: _____
Reviewed & Date: _____	Reviewed & Date: _____	Reviewed & Date: _____
Reviewed & Date: _____	Reviewed & Date: _____	Reviewed & Date: _____
Reviewed & Date: _____	Reviewed & Date: _____	Reviewed & Date: _____
Reviewed & Date: _____	Reviewed & Date: _____	Reviewed & Date: _____