SAN FRANCISCO
OTOLARYNGOLOGY
Providing ear, nose, and throat care since 1940

ADULT HEALTH HISTORY FORM

NAME:_____ DOB:_____

PREFERRED NAME (if other):_____Visit date:_____

Preferred Pronoun (PICK ONE): (he/him/his) (she/her/hers) (they/them/theirs) (decline to answer)

Who referred you to our office?_____Primary care physician:_____

What is the **Main Reason** for your visit today?_____

_____

How long has this problem existed?_____

ALLERGIES/SENSITIVITIES TO MEDICATIONS: (Please describe reaction) □ *NONE*

CURRENT MEDICATIONS WITH DOSAGE: (Please include over the counter and herbal supplements) □ *NONE*

Preferred Pharmacy (Name & Cross Streets [or Ph#]) _____

PAST MEDICAL HISTORY: □ *NONE* Note,only select positive health history findings.

Allergies	☐	HIV/AIDS	☐
Anemia	☐	Kidney disease	☐
Anxiety	☐	Liver disease	☐
Asthma	☐	Pneumonia/Lung disease	☐
Bleeding disorder	☐	Psychiatric disorder	☐
Cancer	☐	Salivary duct stone	☐
Depression	☐	Seizures	☐
Diabetes mellitus	☐	Sinus disorder	☐
GERD (Reflux)	☐	Sleep apnea	☐
Hearing loss	☐	Speech delay	☐
Heart attack	☐	Stomach ulcers	☐
Heart disease	☐	Stroke	☐
High blood pressure	☐	Thyroid disease	☐
High cholesterol	☐	Tuberculosis	☐

OTHER MEDICAL PROBLEMS: _____

_____

PAST SURGICAL HISTORY: □ *NONE* ☐

Adenoidectomy	☐	Facial cosmetic surgery	☐
Bronchoscopy	☐	Nasal/Sinus surgery	☐
Cardiac surgery	☐	Neck surgery	☐
Dental surgery	☐	Orthopedic surgery	☐
Ear surgery	☐	Salivary gland surgery	☐
Ear tubes	☐	Throat surgery	☐
Esophagus surgery	☐	Thyroid surgery	☐
Eye surgery	☐	Tonsillectomy	☐

OTHER SURGICAL HISTORY: _____

_____

FAMILY HISTORY: *(M=mother; F=father; S=sister; B=brother; C= child)* □ Adopted

□ *NONE*	M	F	S	B	C
Allergies					
Anesthesia problems					
Asthma					
Bleeding disorder					
Cancer (type:)					
Diabetes					
Genetic disease					

	M	F	S	B	C
Hearing loss					
Heart disease					
High blood pressure					
Kidney disease					
Psychiatric illness					
Stroke					
Sudden death					

SOCIAL HISTORY:

Smokeless tobacco: □ Current user □ Former user (Quit date_____) □ Never used

Cigarette use: □ Current smoker □ Former smoker (Quit date_____) □ Never smoked

If current or former smoker: # cigarettes/day_____ for _____ years

Alcohol:☐ Yes (drinks per week _____)☐ Not Currently☐ Never

consumed Recreational drugs? ☐Yes ☐Not Currently ☐Never

Occupation_____

FOR FEMALE PATIENTS: Are you pregnant OR trying to get pregnant?

REVIEW OF SYSTEMS: Indicate symptoms you are *currently* experiencing

☐ Decreased appetite	☐ Difficulty breathing	☐ Numbness
☐ Fatigue	☐ Cough	☐ Dizziness
☐ Fever/chills/night sweats	☐ Nausea/vomiting	☐ Headache/migraine
☐ Unintended weight loss	☐ Change in bowel habits	☐ Heat/cold intolerance
☐ Vision changes	☐ Skin rash	☐ Bleed easily
☐ Eye pain	☐ Mental status changes	☐ Bruise easily
☐ Chest pain	☐ Weakness	☐ **NONE OF THE ABOVE**

Form completed by (print):_____

Signature:_____ Date:_____