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

ADULT FORM DATE:_____

NAME:_____ DOB:_____

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*

PAST MEDICAL HISTORY:

Allergies	Y	N	Hypertension	Y	N
Anemia	Y	N	Kidney disease	Y	N
Arthritis	Y	N	Language delay	Y	N
Asthma	Y	N	Liver disease	Y	N
Benign prostatic hyperplasia	Y	N	Lung disease	Y	N
Bleeding disorder	Y	N	Pneumonia	Y	N
Cancer	Y	N	Psychiatric Treatment	Y	N
Chronic bronchitis	Y	N	Salivary Duct Stone	Y	N
Depression	Y	N	Seizures	Y	N
Diabetes mellitus	Y	N	Sinus disorder	Y	N
Ear infection	Y	N	Sleep Apnea	Y	N
GERD	Y	N	Speech delay	Y	N
Hearing aid	Y	N	Stomach ulcers	Y	N
Hearing loss	Y	N	Stroke	Y	N
Heart attack	Y	N	Thyroid disease	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Urinary tract infection	Y	N
HIV/AIDS	Y	N			

OTHER MEDICAL PROBLEMS: _____

_____

PAST SURGICAL HISTORY:

Adenoidectomy	Y	N	Inner ear surgery	Y	N
Appendectomy	Y	N	Middle ear surgery	Y	N
Bronchoscopy	Y	N	Nasal septum surgery	Y	N
Cardiac surgery	Y	N	Nasal surgery	Y	N
Cholecystectomy	Y	N	Neck surgery	Y	N
Colonoscopy	Y	N	Nose surgery	Y	N
Ear tubes	Y	N	Salivary gland surgery	Y	N
Esophagus surgery	Y	N	Sinus surgery	Y	N
External ear surgery	Y	N	Throat surgery	Y	N
Eye surgery	Y	N	Tonsillectomy	Y	N
Facial cosmetic surgery	Y	N	Uvulopalatopharyngoplasty	Y	N

OTHER SURGICAL HISTORY: _____

_____

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

	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:

Cigarette use: □ NONE or #____ /day for ___ years (If you quit, when? _____)
Alcohol (drinks/week)_____ Recreational drugs? Yes_____ No
Occupation_____

FOR FEMALE PATIENTS: Are you pregnant, OR trying to get pregnant? Yes No

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

□ Appetite change
□ Fatigue
□ Fever/chills/night sweats
□ Unintended weight loss
□ Vision changes
□ Eye pain
□ Chest pain
□ Shortness of breath
□ Swelling in hands/feet
□ Difficulty breathing
□ Wheezing
□ Nausea/vomiting
□ Abdominal pain
□ Change in bowel habits
□ Frequent urination
□ Urgency/incontinence
□ Pain with urination
□ Joint pain/swelling
□ Skin rash
□ Mental status changes
□ Weakness
□ Changes in sensation
□ Headache/migraine
□ Heat/cold intolerance
□ Bleed easily
□ Bruise easily

Form completed by (print):_____

Signature:_____ Date:_____