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

ADULT FORM DATE: _____

NAME:_____ DOB:_____

Height: _____ Weight: _____ How did you hear about our office?_____

Who is your primary care physician?_____

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

_____

How long has this problem existed?_____

EARS, NOSE AND THROAT HISTORY: Check all that apply

- □ Hearing problems
- □ Ringing in the ears
- □ Dizziness
- □ Sinus infections
- □ Nasal discharge
- □ Nasal obstruction/mouth breathing
- □ Cough
- □ Snoring/sleep problem
- □ Frequent sore throats
- □ Swallowing problem
- □ Heartburn
- □ Hoarseness
- □ Sores/ulcers in mouth
- □ Head trauma
- □ Salivary gland problem
- □ Swollen lymph nodes

ALLERGIES TO MEDICATIONS: □ *NONE*

_____

_____

List any other allergies, such as to food, pollen, eggs, iodine, shellfish, latex, etc.
□ *NONE* _____

MEDICATIONS: List all prescription and NON-prescription medications (such as Motrin, vitamins, herbal supplements, Mucinex and Tylenol) that you are taking. □ ***NONE***

_____

_____

PAST MEDICAL HISTORY: If yes, please specify

AIDS/HIV	Y	N	Heart attack (When?)	Y	N
Allergies	Y	N	Heart disease	Y	N
Anxiety disorder	Y	N	Hepatitis	Y	N
Arthritis	Y	N	High blood pressure	Y	N
Asthma	Y	N	Immune disorder	Y	N
Attention deficit disorder	Y	N	Lung disease	Y	N
Autoimmune disease	Y	N	Muscle/bone disorder	Y	N
Bleeding disorders	Y	N	Neurological disorder	Y	N
Cancer	Y	N	Seizures	Y	N
Depression	Y	N	Sexually transmitted disease	Y	N
Diabetes	Y	N	Skin rash	Y	N
Eye disease	Y	N	Thyroid disorder	Y	N
GI disorder/Reflux	Y	N	Urinary/kidney disorder	Y	N

PAST HOSPITALIZATIONS/SURGERIES: Indicate year and the reason

_____

_____

SOCIAL HISTORY:
Cigarette use: □ NONE or #____ /day for ___ years (If you quit, how long ago? ____)
Alcohol (drinks/week)_____
Recreational drug use? Yes_____ No
Coffee/Tea (cups/day)_____
Occupation_____

FAMILY HISTORY: *Mark boxes below (M = mother; F = father; S = sibling; C = child)*

	M	F	S	C
Allergies				
Problems w/ anesthesia				
Asthma				
Bleeding problems				
Cancer (type:)				
Diabetes				
Genetic disease				

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

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

PREVIOUS TESTS PEFORMED: Indicate **type, date of test, and where**
Allergy test Y N _____
X-ray, CT, MRI Y N _____
Hearing test Y N _____
Immune test Y N _____

PREGNANCY: Are you pregnant, OR trying to get pregnant? Yes No

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Form completed by (print):_____

Signature:_____ Date:_____