

ADULT FORM – San Francisco Otolaryngology Medical Group

NAME: _____ DOB: _____

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 # ___ /day for ___ years If you have quit, how long ago? _____
Smokers in the house, even if they do not smoke inside? Yes No
Alcohol (drinks/week) _____
Recreational drug use? Yes _____ No
Coffee/Tea (cups/day) _____
Occupation _____

FAMILY HISTORY: Check all that apply for your siblings, parents and grandparents

- | | | |
|---|--|---|
| <input type="checkbox"/> Problems w/ anesthesia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sudden death |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | |

REVIEW OF SYSTEMS: Check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Appetite change | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Mental status changes |
| <input type="checkbox"/> Fever/chills/night sweats | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Unintended weight loss | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Changes in sensation |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Headache/migraine |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Increased thirst |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Urgency/incontinence | <input type="checkbox"/> Heat/cold intolerance |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Bleed/bruise easily |
| <input type="checkbox"/> Swelling in hands/feet | <input type="checkbox"/> Joint pain/swelling | |

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

Form completed by (print): _____

Signature: _____ Date: _____