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

ADULT HEALTH HISTORY FORM

NAME:____ DOB:___________________________

PREFERRED NAME (if other):_________________________ Visit date:________________________

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 & herbal supplements) □ *NONE*

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

PAST MEDICAL HISTORY: □ *NONE*

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

OTHER MEDICAL PROBLEMS: ____

PAST SURGICAL HISTORY: □ *NONE*

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

OTHER SURGICAL HISTORY: ____

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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 (chew/snuff): ☐ Current user ☐ Former user (Quit date___________) ☐ Never used
Tobacco use: ☐ Current smoker ☐ Former smoker (Quit date________________) ☐ Never smoked
If current or former smoker: # cigarettes/day_________________ for _______________ years
Type of use (select all that apply): ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Vape ☐ E-Cigarettes
Alcohol: ☐ Yes (drinks per week ____________) ☐ Not Currently ☐ Never consumed
Recreational drugs? ☐ Yes ☐ Not Currently ☐ Never

Occupation____

FALLS (for patients over 65 years old)**:**
Have you fallen since your last visit or within the last year? If yes, did the fall result in injury? Falling includes unintentionally coming to rest on the ground or other level such as a chair.
☐ No ☐ Yes, without injury (comments:____)
☐ Yes, with injury (comments:____)
In the past 12 months, have you been worried or afraid that you might fall?
☐ No ☐ Yes (comments:____)

INFLUENZA SCREENING:
Have you received the flu vaccine since August 1st?
☐ Yes ☐ No ☐ Cannot receive due to medical contraindication

PREGNANCY (circle one)**:** Are you pregnant OR trying to get pregnant? Yes No Not Applicable

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

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

Form completed by (print):____

Signature:____ Date:_____________________