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*

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: _____

_____

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? Yes No

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:_____