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

HEALTH HISTORY UPDATE FORM

NAME:_____ DOB:_____

PREFERRED NAME (if other):_____ Visit date:_____

Pronoun (Pick one): (he/him/his) (she/her/hers) (they/them/theirs) (decline to answer) (_____)

1) Since your last visit, have you developed new medical problems? Yes No

If yes, please describe_____

2) Since your last visit, were you admitted to the hospital? Yes No

If yes: when, where, and why?_____

3) Since your last visit, have you had any surgery/procedures? Yes No

If yes: when and what?_____

4) Since your last visit, have you developed any new allergies, or had a bad reaction to any medication or food? Yes No

If yes, please describe_____

5) Since your last visit, have you started any new medications, or changed any medications you were taking? Yes No

If yes, please describe_____

6) Please describe your tobacco use in the last year:

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

7) 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:_____)

8) INFLUENZA SCREENING:

Have you received the flu vaccine since August 1st?

□ Yes □ No □ Cannot receive due to medical contraindication

Form completed by (print):_____

Signature:_____ Date:_____