MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE

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Adult Health History Form

Name:_____ DOB:_____ Date:_____

Referring Physician:_____ Primary Physician:_____

Main Reason for Today's Visit:_____

Preferred Pharmacy

Name:_____ Location:_____

Personal Medical History: Please, indicate whether you have had any of the following medical problems:

□ Heart Disease:
Specify type:_____
□ Asthma/Lung Disease
□ Cancer (specify):_____
□ High Blood Pressure
□ Diabetes
□ Sleep Apnea
□ Other (specify):_____
□ Thyroid Problem
□ Acid Reflux
□ Bleeding Disorder

Surgical History: Please, list all prior operations – with dates.

Procedure:	Date	Procedure	Date
_____		_____	
_____		_____	

Medications: Prescription and non-prescription medications, vitamins, supplements, herbals, ect.

Medication:	Dose:	Medication:	Dose:
_____		_____	
_____		_____	
_____		_____	

Allergies: please, list any allergies to medications along with reaction.

Allergic to:	Reaction	Allergic to:	Reaction:
_____		_____	
_____		_____	

Do you have environmental or food allergies Yes/No
If Yes, what:_____

Have you ever been evaluated with allergy tests? Yes/No

Family History: Indicate family members (parents, sibling, grandparent, aunt or uncle) with the following:

□ Heart Disease	□ High Blood Pressure	□ Thyroid Problem
□ Stroke	□ Diabetes	□ Headaches
□ Asthma/Lung Disease	□ Sleep Apnea	□ Bleeding Disorder
□ Cancer (specify)_____	□ Hearing Loss	□ Problems with anesthesia

Social History:

Occupation:_____

Tobacco Use:
Cigarettes? □ Never □Quit Date □Current Smoker: packs/day_____# of years_____
Other Tobacco? □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use:
Do you drink alcohol? □ No □ Yes Drinks/Week_____

Drug Use:
Do you use recreational drugs? □ No □ Yes

Caffeine Intake: □ None □ Coffe/Tea/Soda – Cups/Day_____

Review of Systems: Do you have problems with any of the following?

General Health:	□No	□Fever □Unintentional weight loss
Sleeping:	□ No	□ Snoring □ Apnea □ Waking up Tired □ Daytime Tiredness
Eyes:	□No	□ Visual Loss □ Blurry Vision □ Itchy Eyes □ Tearing
Ears:	□ No	□ Dizziness □ Ringing □ Hearing Loss □ Earache □ Drainage
Nose:	□ No	□ Drainage □ Congestion □ Post-nasal Drip□ Bleeding □ Sneezing
Mouth & Throat:	□ No	□ Sore Throat □ Hoarseness □ Voice Change □ Problem Swallowing □ Dentures □ Mouth Sores
Neck:	□ No	□ Pain □ Lumps □ Thyroid Nodule □ Swollen Glands
Cardiovascular:	□ No	□ Chest Pain □ Irregular Heart beat □ Murmurs □ Swelling □ Heart Valve Disease
Lungs:	□ No	□ Chronic Cough □ Wheezing □ Shortness of Breath □ Positive TB Test
Gastrointestinal:	□ No	□ Heartburn □ Abdominal Pain □ Nausea □ Vomiting □ Diarrhea
Genitourinary:	□ No	□ Frequent Nighttime Urination □ Pain □ Incontinence □ Bloody urine
Musculoskeletal:	□ No	□ Muscle Pain □ Back Pain □ Neck Pain □ Joint Pain
Neurological:	□ No	□ Headaches □ Migraines □ Tremors □ Numbness □ Memory loss
Psychiatric:	□ No	□ Anxiety □ Nervousness □ Depression □ Mood Swings
Endocrine:	□ No	□ Increased Appetite □ Feeling hot when others are not □ Cold □ Recent Weight Changes - □Gain □Loss
Blood/Lymph:	□ No	□ Slow to Heel after Cuts □ Bruise Easily □ Anemia □ Bleeds Excessively □ Unexplained Lumps
Skin:	□ No	□ Rash □Hives

Signatures:_____ **Date:**_____

Relationship to Patient (if other than self)_____