MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE

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# Adult Health History Form

Patient 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:

Procedure: Date: Procedure: Date:
_____________________________________________________ _____________________________________________________
_____________________________________________________ _____________________________________________________

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

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 Have you ever had any allergy tests done? Yes No

If Yes, to what? ___________________________________________________________________________________________

**Family History**: Please indicate if family members (parents, siblings, grandparents, aunts or uncles) have a history with the following:

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

**Social History:**

Occupation: _______________________________________________________________________________________________

Do you smoke cigarettes? □ Never □Quit Date __________ □Current Smoker: packs/day_____# of years________

Other Tobacco/Nicotine? □ Pipe □ Cigar □ Snuff □ Chew □ Vape

Do you drink alcohol? □ No □ Yes # of Drinks/Week___________

Do you use recreational drugs? □ No □ Yes _______________________________________________

Caffeine Intake: □ None □ Coffee/Tea/Soda – Cups/Day__________

# REVIEW OF SYMPTOMS

**Do you currently have, or have recently experienced, any of the below symptoms?**

| GENERAL | YES | NO |
|---|---|---|
| Fatigue | □ | □ |
| Fever | □ | □ |
| Weight gain | □ | □ |
| Weight loss | □ | □ |

| SLEEP | YES | NO |
|---|---|---|
| Snore | □ | □ |
| Apnea | □ | □ |
| Insomnia | □ | □ |
| Waking up tired | □ | □ |
| Daytime tiredness | □ | □ |

| EYES | YES | NO |
|---|---|---|
| Visual loss | □ | □ |
| Blurry vision | □ | □ |
| Itchy eyes | □ | □ |
| Watery eyes | □ | □ |

| EARS | YES | NO |
|---|---|---|
| Dizziness | □ | □ |
| Ringing | □ | □ |
| Hearing loss | □ | □ |
| Ear pain | □ | □ |
| Ear drainage | □ | □ |

| NOSE | YES | NO |
|---|---|---|
| Post nasal drip | □ | □ |
| Nasal drainage | □ | □ |
| Nosebleeds | □ | □ |
| Sneezing | □ | □ |
| Congestion | □ | □ |

| MOUTH/THROAT | YES | NO |
|---|---|---|
| Sore throat | □ | □ |
| Hoarseness | □ | □ |
| Voice changes | □ | □ |
| Problem swallowing | □ | □ |
| Dentures | □ | □ |

| NECK | YES | NO |
|---|---|---|
| Swollen glands | □ | □ |
| Neck pain | □ | □ |
| Neck lumps | □ | □ |
| Thyroid nodule | □ | □ |

| RESPIRATORY | YES | NO |
|---|---|---|
| Chronic cough | □ | □ |
| Wheezing | □ | □ |
| Shortness of breath | □ | □ |

| HEART | YES | NO |
|---|---|---|
| Chest pain | □ | □ |
| Murmur | □ | □ |
| Swelling/Edema | □ | □ |
| Palpitations | □ | □ |

| GI | YES | NO |
|---|---|---|
| Heartburn | □ | □ |
| Abdominal pain | □ | □ |
| Nausea | □ | □ |
| Vomiting | □ | □ |
| Diarrhea | □ | □ |

| URINARY | YES | NO |
|---|---|---|
| Blood in urine | □ | □ |
| Frequent nighttime urination | □ | □ |
| Incontinence | □ | □ |

| MUSCULOSKELETAL | YES | NO |
|---|---|---|
| Muscle pain | □ | □ |
| Joint pain | □ | □ |
| Back pain | □ | □ |
| Neck pain | □ | □ |

| NEUROLOGIC | YES | NO |
|---|---|---|
| Headaches | □ | □ |
| Migraines | □ | □ |
| Memory loss | □ | □ |
| Numbness | □ | □ |
| Tremors | □ | □ |

| PSYCH | YES | NO |
|---|---|---|
| Depression | □ | □ |
| Anxiety | □ | □ |
| Mood swings | □ | □ |

| ENDOCRINE | YES | NO |
|---|---|---|
| Increased appetite | □ | □ |
| Feel hot when others do not | □ | □ |
| Feel cold when others do not | □ | □ |

| BLOOD/LYMPH | YES | NO |
|---|---|---|
| Slow to heal after cuts | □ | □ |
| Bruise easily | □ | □ |
| Bleeds excessively | □ | □ |
| Unexplained lumps | □ | □ |

| SKIN | YES | NO |
|---|---|---|
| Rash | □ | □ |
| Hives | □ | □ |

**Signature:**_______________________________________________________________________ **Date:**____________________________

Relationship to Patient (if other than self) _______________________________________________________________________________