NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Road, Suite A
Oceanside, California 92056
(760) 726-2440 Fax (760)726-0644

ADULT PATIENT MEDICAL HISTORY FORM

1. Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ Height _____ Weight_____

Referring Provider _____ **Primary Care Provider** _____

2. Chief complaint: What is the reason for your visit?

_____

3. Past medical history: Medical problems for which you have **previously** been treated or are **currently** being treated. If yes, please circle specific conditions and provide details if needed. Please add any others not listed.

YES	NO	
☐	☐	Acid reflux _____
☐	☐	AIDS/HIV _____
☐	☐	Anesthesia problems _____
☐	☐	Arthritis _____
☐	☐	Bleeding problems (eg nose, surgical, gums, menstrual cycle) _____
☐	☐	Blood clots _____
☐	☐	Cancer/what type? _____
☐	☐	Dementia (eg Alzheimer's) _____
☐	☐	Depression, bipolar, anxiety, other _____
☐	☐	Diabetes _____
☐	☐	Environmental allergies _____
☐	☐	Glaucoma _____
☐	☐	Hearing problems_____

YES	NO	
☐	☐	Heart disease (heart attack, A-fib, murmur, other) _____
☐	☐	Hepatitis (type A, B, C) _____
☐	☐	Hypertension (high blood pressure) _____
☐	☐	Immune problems_____
☐	☐	Kidney disease _____
☐	☐	Lung Disease (asthma, pneumonia, tuberculosis, other) _____
☐	☐	Migraines _____
☐	☐	Rheumatic fever_____
☐	☐	Sleep apnea _____
☐	☐	Stroke _____
☐	☐	Thyroid disease_____

Other

_____

_____

5. Surgical history: Please list **any surgeries** and the **dates** they were performed:

_____

_____

_____

Patient Name _____ **Date of Birth** _____

6. Social history:

YES NO

☐ ☐ Have you ever or do you now use tobacco?

If yes, how many cigarettes/cigars/pipes per day:_____

For how many years: _____

Quit date: _____

Do you want to quit? _____

YES NO

☐ ☐ Do you drink alcohol?

If yes, average number of drinks per week:_____

☐ ☐ Do you use marijuana? _____

☐ ☐ Recent illegal drug use? _____

Current occupation:_____ **Prior occupations**:_____

7. Family history: Please list any medical problems that run in the FAMILY (e.g. bleeding problems, anesthesia problems, chronic illnesses, heart disease, cancer, high blood pressure, stroke, etc.):_____

_____

8. Other questions:

YES NO

☐ ☐ Currently pregnant _____

☐ ☐ Breastfeeding _____

☐ ☐ Do we have your approval to obtain an HIV test if indicated?

9. Review of systems: If yes, please **circle**. Add additional information if needed.

YES NO

☐ ☐ **Constitutional:** Fevers, unintentional weight loss, recent cold or flu_____

☐ ☐ **Eyes:** Decreased vision, double vision _____

☐ ☐ **CV:** Chest pain, racing heart _____

☐ ☐ **Pulm**: Shortness of breath, wheezing, coughing spells _____

☐ ☐ **GI:** Nausea, vomiting, diarrhea, abdominal pain _____

☐ ☐ **GU:** Pain when urinating, blood in urine _____

☐ ☐ **MSK:** Sore or painful joints, sore or painful muscles, leg swelling _____

☐ ☐ **Derm/Heme:** Rashes, eczema, excessive bleeding or easy bruising _____

☐ ☐ **Neuro:** Dizziness, fainting, headaches, weakness in arms or legs _____

☐ ☐ **Psych:** Depressed, anxious _____

10. Signature of patient or legal guardian _____ **Date** _____

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ADULT PATIENT MEDICATION FORM Today's Date _____

1. Patient Name: _____ **Date of Birth** ___/____/____

2. Pharmacy information: Please list the name, phone number and address of your preferred **pharmacy**:

Pharmacy name: _____ Phone Number: _____

Street Address: _____ City_____ ZIP Code _____

3. Medications: Please list **all** medications you are currently taking (including herbal supplements, vitamins, aspirin, nasal sprays, other "over-the-counter" medications, etc.) and **dosage:**

Check here if none ☐

Medication	**Dosage**	**Medication**	**Dosage**

4. Allergies: Please list any allergies and the type of reaction (include medications, latex, xray dye, food, environmental):

Check here if none ☐
