

NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.

Pediatric and Adult
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(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 condition 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 _____
- Head or neck radiation _____
- 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? _____

Other 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 _____

Date of last menstrual period _____

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 _____