

ADULT HISTORY

Name _____ Date _____

Occupation _____ Age _____ M F

Referring Doctor _____ Primary Care Doctor _____

Reason for Visit: _____

Past Medical History: Please check if you have or have had problems with the following (where appropriate, indicate your specific diagnosis):

- Diabetes** (sugar) **High Blood Pressure** **Heart** (diagnosis _____)
- Lung** (diagnosis _____) **Kidneys** (diagnosis _____)
- Neurologic** (diagnosis _____) **Cancer** (type _____)
- GERD** (acid reflux) **Stroke** **HIV/AIDS** **Liver** (diagnosis _____)
- Thyroid disorders** (diagnosis _____) OTHER: _____

Previous Surgery (please list) _____

Drug Allergies (please list) _____

Environmental Allergies (please list) _____

Previous allergy testing? Yes No (Date tested _____) **Allergy shots?** Yes No

Alcohol: Yes No How much _____ per day? Recovering alcohol dependent? Yes No Age quit _____

Recreational Drug Use: Yes No Type _____ How Long? _____ Age quit _____

Smoking/Tobacco: Yes No How much _____ per day? How old when started? _____ Age quit _____

Review of Systems: Please indicate yes or no, if you have any of the following symptoms:

General

- Fatigue Yes No
- Weight Gain Yes No
- Fever Yes No
- Weight Loss Yes No

Eyes

- Blurred vision Yes No
- Double vision Yes No

Ear, Nose, & Throat

- Hearing Loss Yes No
- Ear Drainage Yes No
- Difficulty Swallowing Yes No
- Nose Congestion Yes No
- Tinnitus/Ear Ringing Yes No
- Ear Pain Yes No
- Painful Swallowing/Sore Throat Yes No
- Nose Bleeds Yes No
- Dizzy/Balance Problems Yes No
- Noise Exposure Yes No
- Hoarseness Yes No

Cardiovascular

- Chest Pain Yes No
- Irregular Heartbeats Yes No

Respiratory

- Shortness of Breath Yes No
- Cough Yes No
- Cough with Blood Yes No

Gastrointestinal

- Heartburn Yes No
- Indigestion Yes No
- Irritable Bowel Yes No

Genitourinary

- Prostate Problems Yes No
- Urinating Problems Yes No

Skin

- Rash Yes No
- Itching Yes No
- New Skin Lesions Yes No

Neurologic

- Headache Yes No
- Seizures Yes No

Musculoskeletal

- Fibromyalgia Yes No
- Joint Pain Yes No
- Muscle Ache Yes No

Psychiatric

- Depression Yes No
- Suicide Attempt Yes No
- Anxiety Yes No

Hematologic

- Easy Bleeding Yes No
- Easy Bruising Yes No

Other: _____

Family History: Has anyone in family had:

Pollen Allergies Yes No (Relation/Type) _____ Heart Disease Yes No (Relation/Type) _____

Menieres Disease Yes No (Relation/Type) _____ Diabetes (Sugar) Yes No (Relation/Type) _____

Complications from Anesthesia (Relation/Reaction) _____

Bleeding Problems Yes No (Relation/Type) _____ Hearing Loss Yes No (Relation/Type) _____

Migraine Headaches Yes No (Relation/Type) _____ Cancer Yes No (Relation/Type) _____

High Blood Pressure Yes No (Relation/Type) _____ Unknown: Family History of Adoption Yes No

*If no medications, please check here NONE

MEDICATION	DOSAGE (strength)	TYPE (pill, patch, injection, etc.)	FREQUENCY (how many times per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
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