**Otolaryngology – Head & Neck Surgery**
Adult Health Survey

Patient's name: _____DOB: _____ Date: _____

| **Past and Current Medical Problems** – *Please check either yes or no.* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Y** | **N** | | **Y** | **N** | | **Y** | **N** | |
| | | Asthma | | | High Blood Pressure | | | Colitis |
| | | Migraine Headaches | | | Irregular Heart Beat | | | Kidney Stones |
| | | Stroke/TIA | | | Rheumatic Fever | | | Thyroid Disorders |
| | | TB/Valley Fever | | | Heart valve problems | | | Diabetes Mellitus |
| | | Glaucoma | | | Hiatal Hernia | | | Melanoma |
| | | Heart Attack | | | Hepatitis | | | Depression |

| **Family Medical History** – *Please indicate yes or no if any of your family members, such as grandparents, aunts, uncles, brothers, sisters, or cousins, have any of the following diseases.* | | | |
|---|---|---|---|
| **Disease** | **Yes** | **No** | **If Yes, State Relationship** |
| Allergies | | | |
| Bleeding Disorders | | | |
| Anesthetic Reactions | | | |
| Thyroid Cancer | | | |
| Hearing Loss | | | |

| **Social History** – *Please check either yes or no.* | | |
|---|---|---|
| **Yes** | **No** | |
| | | Do you smoke cigarettes, cigars, a pipe or other? |
| | | Have you quit smoking within the past ten years? |
| | | Do you use smokeless tobacco? |
| | | Do you drink alcohol? |

| **Current Medications** – *If you have a list, please ask our receptionist to make a copy of it for you. If none, please indicate as "none".* | | |
|---|---|---|
| | | |
| | | |
| | | |

| **Allergies** – *Please list allergies to medications, or foods. If none, please indicate as "none".* | |
|---|---|
| **Substance** | **Type of Reaction** |
| | |
| | |
| | |
| | |

**More on the reverse side.**

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Reviewed by _____Date: _____

Patient's name: _____DOB: _____ Date: _____

| **Previous Surgeries** – *If none, please indicate as "none".* | |
|---|---|
| **Date** | **Type of Illness** |
| | |
| | |
| | |
| | |
| | |

| **Previous Non-Surgical Hospitalizations** – *If none, please indicate as "none".* | |
|---|---|
| **Date** | **Type of Illness** |
| | |
| | |
| | |
| | |
| | |

| **Review of Systems** – *Please check each box for symptoms that apply.* ***Check N/A Only if None Apply!*** |
|---|
| ○ Fatigue ○ Weight loss ○ Fever ○ Night sweats ○ Weight gain ○ N/A |
| ○ Rashes ○ Itching ○ Hives ○ Skin cancer ○ N/A |
| ○ Seasonal allergies ○ Sneezing ○ N/A |
| ○ Ringing in ears ○ Hearing loss ○ Nasal discharge or blockage ○ Hoarseness ○ Sore throat ○ N/A |
| ○ Vision changes ○ Double Vision ○ Headaches ○ Blackout spells ○ N/A |
| ○ Shortness of breath ○ Snoring ○ Daytime sleepiness ○ Wheezing ○ Cough ○ N/A |
| ○ Chest pain ○ Skipped heartbeats ○ N/A |
| ○ Swallowing difficulty ○ Indigestion ○ N/A |
| ○ Excessive bleeding or bruising ○ Swollen glands ○ N/A |
| ○ Back pain ○ Swelling in joints ○ Stiffness ○ N/A |
| ○ Anxiety ○ Depression ○ Stress ○ N/A |
| ○ Excessive thirst ○ Hair loss ○ Dry Skin ○ N/A |

**Thank you for your cooperation!**

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