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.

OFFICE USE ONLY
Reviewed by _____Date: _____

Dignity Health.
Pacific Central Coast Health Centers

Higuera Health Center
1555 Higuera Street
San Luis Obispo, CA 93401
Phone 805.541.2368 • Fax 805.556.3009

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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