

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

Patient's name: \_\_\_\_\_

Date: \_\_\_\_\_

**Past & 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 including supplements and vitamins**  
*(If you have a list please ask our receptionist to make a copy 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: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Date: \_\_\_\_\_

Previous Surgeries- <i>If none, please indicate as "none"</i>	
DATE	TYPE OF ILLNESS

Previous Non-Surgical Hospitalizations - <i>If none, please indicate as "none"</i>	
DATE	TYPE OF ILLNESS

Review of Systems – <i>Please check each box for symptoms that apply, CHECK N/A ONLY IF NONE APPLY!!!!</i>					
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Weight gain	<input type="checkbox"/> N/A
<input type="checkbox"/> Rashes	<input type="checkbox"/> Itching	<input type="checkbox"/> Hives	<input type="checkbox"/> Skin cancer	<input type="checkbox"/> N/A	
<input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> Sneezing	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Nasal discharge or blockage	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sore throat	<input type="checkbox"/> N/A
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Blackout spells	<input type="checkbox"/> N/A	
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Snoring	<input type="checkbox"/> Daytime sleepiness	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> N/A
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Skipped heartbeats	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Swallowing difficulty	<input type="checkbox"/> Indigestion	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Excessive bleeding or bruising	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Back pain	<input type="checkbox"/> Swelling in joints	<input type="checkbox"/> Stiffness	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Stress	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	

***Thank you for your cooperation!***

**OFFICE USE ONLY**

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_