

USE THIS FORM FOR OVER 18 YEARS OF AGE

ADULT ROS / PMHx

Eastside ENT Specialists, Inc.

Name _____ Today's Date _____

Have you ever had these medical problems?

EYES:

Cataracts Yes No
Glaucoma Yes No

EARS:

Hearing loss Yes No
Ringing Yes No
Dizziness Yes No
Pressure in ears Yes No
Noise exposure Yes No

HEART:

High blood pressure Yes No
Heart disease Yes No
Cholesterol Yes No
Rhythm problems Yes No
Angina Yes No

PULMONARY:

Asthma Yes No
Chronic cough Yes No
Pneumonia Yes No
Emphysema Yes No

GASTRO-INTESTINAL:

Heartburn Yes No
Ulcers Yes No
Liver disease Yes No
Colon polyps Yes No
Diverticulitis Yes No
Colitis Yes No
Hepatitis Yes No

URINARY:

Urinary infections Yes No
Kidney disease Yes No
Incontinence Yes No
Prostate problems Yes No

OB-GYN:

Breast problems Yes No
Endometriosis Yes No

MUSCULO-SKELETAL:

Arthritis Yes No
Neck/spinal problems Yes No
Lower back Yes No
Fractures Yes No

NEUROLOGICAL:

Nerve pain Yes No
Headaches Yes No
Migraines Yes No
Strokes Yes No
Seizures Yes No

ENDOCRINE:

Diabetes Yes No
Thyroid Yes No

MOOD:

Depression Yes No
Anxiety Yes No

SKIN:

Eczema Yes No
Rash Yes No
Hives Yes No

HEMATOLOGY:

Anemia Yes No
Bleeding tendency Yes No
Clots in legs, lungs Yes No
Lymphoma Yes No

IMMUNOLOGIC:

Immune deficiency Yes No
HIV exposure Yes No

CURRENT MEDICATIONS: _____

SURGERY: _____

TUMORS: _____

SOCIAL HISTORY: Occupation _____ Children _____

Tobacco _____ Date quit _____ Amount _____ Alcohol _____

FAMILY MEDICAL PROBLEMS: Diabetes _____ Heart trouble _____

Bleeding tendencies _____ Cancer _____

ALLERGIES TO ENVIRONMENT:

(Hay fever, pollens, animals) _____

DRUG ALLERGIES: _____