Mercy Clinics
EAR, NOSE AND THROAT CLINIC
A member of Mercy Medical Center–Des Moines

Adult History Form

Today's Date: ____________________ **Birthdate:** ____________________ **Age:** ____________

Patient's Name: ______________________________ **Occupation:** ____________________

Family Physician's Name: ______________________________ **Referring Physician:** ____________________

Drug Allergies: ____

Reason for your visit today: ____

____

Marital Status (please circle): single married divorced

Occupation: ____

Tobacco: Have you been or are you now a smoker?
How many packs per day? ________ For how many years? ________
If a previous smoker, when did you quit? ________
Are you exposed to second hand smoke? ________

Alcohol: How many alcoholic beverages do you consume on a weekly basis? ________

Medications (name & dose):

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Supplements/Herbs e.g. St. John's Wort Ginkgo Biloba Echinacea

Other ____________________ ____________________ ____________________

MEDICAL HISTORY

Please circle any illnesses you have had in past

Neurology	headaches	seizures	stroke	MS	other
Psychiatric	depression	schizophrenia	bipolar disease	eating disorder	other
Ear	otitis media	perforation	mastoiditis	cholesteastoma	other
Nose	sinusitis	deviated septum	allergic rhinitis	polyps	other
Mouth	tonsillitis	pharyngitis	cancer	Salivary gland problems	other
Throat	laryngitis	nodules	polyps	Zenker's diverticulum	other
Lungs	asthma	bronchitis	COPD	pneumonia	other
Heart	hypertension	heart attack	arrythmia	heart failure	other
GI	reflux	ulcers	hepatitis	cancer	other
Urologic	prostate cancer	prostate enlargement	incontinence	prostatitis	other
Renal/Bladder	kindey stones	urinary tract infection	cancer	Congenital abnormality	other
Rheum	rheumatoid arthritis	Wegener's Granulomatosis	Lupus	polymyalgia	other
Endocrine	diabetes	hypothyroid	hyperthyroid	pituitary problems	other
Hematology	anemia	bleeding disorder	leukemia	platelet abnormalities	other
Orthopoedic	hip replacement	knee replacement	shoulder surgery	osteoarthritis	other

Please List Any Hospitalizations You Have Had:

____________________ ____________________ ____________________

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Have you been advised to take antibiotics prior to dental procedures or other surgery? Yes No

Do you have any artificial joints? Yes No

Do you have a pacemaker? Yes No

SURGICAL HISTORY

Please list any previous surgeries you have had: None

____________________ ____________________ ____________________

____________________ ____________________ ____________________

FAMILY HISTORY

Please make a check mark in any boxes that apply. Please list the type or site of cancer if known.

	Alive or Deceased									
	(A) or (D)	Age or age at death	Stroke	Hearing Loss	Heart Disease	Hight Blood Pressure	Diabetes	Cancer (Type)	Asthma or Allergies	Other
Father	A D									
Mother	A D									
Siblings										
	A D									
	A D									
	A D									
	A D									
	A D									

Do you have any family members who experienced high fevers or life threatening complications from general anesthesia? Yes No

Do you have any family members who have hemorrhaged following surgery or have a history of a bleeding disorder? Yes No

REVIEW OF SYSTEMS

Please circle any symptoms which you may be experiencing

General	fatigue	weight loss	chills	bruise easily	loss of appetite	night sweats
Mood	depression	anxiety	worry	flight of ideas	anger	
Sleep	snoring	insomnia	quit breathing	nightmares		
Neuro	headaches	memory loss	loss of consciousness	change in personality	seizures	
Ear	hearing loss	ringing	dizziness	pain	drainage	itching
Eye	vision loss	double vision	blurred vision	pain	floaters	
Nose	obstruction	congestion	sneezing	drainage	bleeding	loss of smell
Mouth	sores	masses	pain	loss of taste	sore throats	bleeding
Neck	masses	hoarseness	swallowing difficulty	pain	lump sensation	
Lungs	short of breath	wheezing	cough	cough up blood	pain with breathing	
Heart	chest pain	palpitations	arm pain	jaw pain	ankle swelling	
GI	heartburn	indigestion	abdominal pain	constipation	diarrhea	blood in stool
Urologic	painful urination	blood in urine	incontinence	difficulty urinating	frequent urination	
Ortho	joint aches	muscle aches	stiffness in joints	red/swollen joints	back pain	
Endocrine	thirst	frequent urination	dry skin	feeling warm of cold		
Skin	rashes	eczema	psoriasis	acne		
Allergy	sneezing	runny nose	watery eyes	itchy eyes		

Signature: ____

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