THE UNIVERSITY OF ARIZONA MEDICAL CENTER
University Campus

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MEDICAL RECORD#

DOB

NAME

VISIT#

ADULT OTOLOGY
PATIENT INITIAL VISIT

Please provide the following information to the best of your ability:

What problem(s) are you here for today?_____

_____

PAST MEDICAL HISTORY:

1) PLEASE CHECK THE "YES" OR "NO" BOX TO INDICATE IF YOU HAVE/HAD ANY OF THE FOLLOWING ILLNESSES: FOR "YES" ANSWERS, PLEASE EXPLAIN:

	YES	NO			YES	NO	
DIABETES	❑	❑		KIDNEY PROBLEMS	❑	❑	
HIGH BLOOD PRESSURE	❑	❑		NEUROLOGICAL PROBLEMS	❑	❑	
HEART DISEASE	❑	❑		CANCER	❑	❑	
BLEEDING DISORDER	❑	❑		DEPRESSION/ANXIETY	❑	❑	
LUNG (ASTHMA, BRONCHITIS)	❑	❑		ALLERGY PROBLEMS / THERAPY	❑	❑	
LIVER PROBLEMS	❑	❑		OTHER MEDICAL PROBLEMS	❑	❑	

_____

_____

2) PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS (AND DATES) YOU HAVE EVER HAD (INCLUDING TONSILS & ADENOIDS):

SURGERIES/HOSPITALIZATIONS	YEAR	SURGERIES/HOSPITALIZATIONS	YEAR

ANESTHESIA PROBLEMS: ☐ YES ☐ NO _____

3A) PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING DOSAGE AND TIMES PER DAY):

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

3B) LIST ANY **ALLERGIES** TO MEDICATIONS:

FAMILY HISTORY:

1) PLEASE CHECK THE "YES" OR "NO" BOX TO INDICATE WHETHER ANY RELATIVES HAVE ANY OF THE FOLLOWING ILLNESSES/PROBLEMS:

2) FOR "YES" ANSWERS, PLEASE INDICATE WHICH RELATIVE(S) HAS/HAVE THE PROBLEM AND EXPLAIN

	YES	NO	
HEARING LOSS	☐	☐	
BLEEDING DISORDER	☐	☐	
CANCER	☐	☐	
HEART DISEASE	☐	☐	
DIABETES	☐	☐	
ANESTHESIA PROBLEMS	☐	☐	
OTHER MEDICAL PROBLEMS	☐	☐	

_____

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SOCIAL HISTORY:

Are you presently: ☐ Working ☐ Retired ☐ Disabled Occupation (or previous occupation):_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Level of Education ☐ Grade _____ ☐ Technical / Trade School ☐ College Degree ☐ Post-Graduate Degree

Do you have children? ☐ Yes ☐ No How many? _____ **Do you live alone?** ☐ Yes ☐ No

Do you smoke?

- ☐ Yes, I've smoked _____ pack(s) of cigarettes per day for _____ years
- ☐ Yes, I smoke cigarettes occasionally, but not everyday
- ☐ Yes, I smoke cigars or a pipe
- ☐ No, I quit smoking _____ years ago. At that time I was smoking _____ pack(s) per day for _____ years
- ☐ No, I've never smoked

Do you drink alcohol?

- ☐ Yes, daily
- ☐ Yes, 1 or more times per week
- ☐ Yes, 1 or more times per month
- ☐ No, but I have previously
- ☐ No, never (or rarely)

Do you use recreational or illegal drugs?

- ☐ Yes, presently
  Type/Frequency:_____
- ☐ No, but I have previously
  Type/Frequency:_____
- ☐ No

Caffeine Intake:_____ per day **Exercise:** ☐ Yes ☐ No **Type/Frequency:**_____

Have you been exposed to significant noise? (Factory work / guns / military) ☐ Yes ☐ No **Type/Frequency:**_____

REVIEW OF SYSTEMS:

1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:

2) For any "Yes" answers, please check the "Current" box if this symptom relates to the reason for your visit today

		Yes	No	Current		Yes	No	Current
GENERAL	Fever	☐	☐	☐	Weight loss ☐ or gain ☐	☐	☐	☐
EYES	Wear glasses	☐	☐	☐	Injuries/Trauma	☐	☐	☐
CARDIOVASCULAR	Chest pain	☐	☐	☐	Irregular pulse	☐	☐	☐
RESPIRATORY	Chronic cough	☐	☐	☐	Shortness of breath	☐	☐	☐
NEUROLOGICAL	Fainting	☐	☐	☐	Chronic headache	☐	☐	☐
PSYCHIATRIC	Depression	☐	☐	☐	Anxiety	☐	☐	☐
	Schizophrenia	☐	☐	☐	Manic/Depression	☐	☐	☐
SKIN	Rash	☐	☐	☐	Itching	☐	☐	☐
	Hives	☐	☐	☐	Skin lesion(s)	☐	☐	☐
MUSCULOSKELETAL	Joint pain	☐	☐	☐	Muscle pain	☐	☐	☐
GI	Nausea	☐	☐	☐	Vomiting	☐	☐	☐
ENDOCRINE	Excessive thirst	☐	☐	☐	Feel warmer than others	☐	☐	☐
					Feel cooler than others	☐	☐	☐
HEME/LYMPH	Swollen glands	☐	☐	☐	Bleeding problems	☐	☐	☐
ALLERGY	Food allergies	☐	☐	☐	Inhalant allergies	☐	☐	☐
ENT	Ear pain	☐	☐	☐	Ear drainage	☐	☐	☐
	Ear pressure	☐	☐	☐	Tinnitus/Ear noises	☐	☐	☐
	Hearing loss	☐	☐	☐	Vertigo (spinning)	☐	☐	☐
	Imbalance	☐	☐	☐	Nasal congestion	☐	☐	☐
	Hoarseness	☐	☐	☐	Sore throat	☐	☐	☐
	Wear Hearing Aid	☐	☐	☐	Facial Numbness	☐	☐	☐

Other: _____

Reviewed by: _____ Date: _____ Military Time: _____