Dr. J. Patrick O'Neal

Otolaryngology (ENT)

Adult Patient History and Intake Form

Patient Name ____________________ Date of Birth ____________________

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated Occupation ____________________

Smoking: No Yes If so, what type?____________ Daily Amount______________ Number of Years___________

Alcohol: No Yes If so, what type?____________ Weekly Amount____________

IV or Recreational drugs: No Yes

Please circle any of the following conditions that you have been diagnosed with:

Diabetes	High Blood Pressure	High Cholesterol	Heart Disease
Stroke	Peripheral Vascular Disease (poor circulation)		HIV/AIDS
Seizures	Congestive Heart Failure	Asthma	Emphysema
COPD	Seasonal Allergies	Eczema	Heart Murmur
Hepatitis____	Depression	Kidney Disease	Arthritis
Thyroid Disease	Heart Arrhythmia	Sleep Apnea	Liver Disease
Heart Attack	Cancer (type)____________________		

Other Medical Problems____________________

List all surgeries ____________________

List current medications ____________________

List drug allergies ____________________

Family History: Please check any of the following diseases that the parents, siblings, children, or other close relatives have and indicate the relative.

Heart Disease ____________________ High Blood Pressure ____________________

Stroke ____________________ Bleeding Problems ____________________

Cancer/Tumors ____________________ Kidney Problems ____________________

Diabetes ____________________ Stomach Problems ____________________

Intestinal Problems ____________________ Seizures ____________________

Headaches ____________________ Arthritis at young age ____________________

Hearing loss at young age ____________________ Any other family illnesses or early deaths ____________________

Please indicate if any of the following apply to you now or in the past:

Now	Past	**Ear, Nose, Throat**
____	____	Noise exposure
____	____	Head injury or concussion
____	____	Draining ears
____	____	Painful ears
____	____	Hearing Loss
____	____	Ringing in ear
____	____	Dizziness or loss of balance
____	____	Chronic facial pain
____	____	Headaches
____	____	Chronic nasal congestion
____	____	Runny nose
____	____	Frequent nose bleeds
____	____	Difficulty swallowing
____	____	Hoarseness
____	____	Throat pain
____	____	Jaw pain
____	____	Chronic cough
____	____	Tooth pain
____	____	Loose teeth/bite problems
____	____	Snoring
____	____	Double vision
____	____	Eye pain
____	____	Change in vision
		General
____	____	Unexplained weight loss
____	____	Unexplained weight gain
____	____	Night sweats
____	____	Joint pains and swelling
		Lungs
____	____	Coughing up blood
____	____	Persistent wheezing
____	____	Shortness of breath
____	____	Abnormal chest x-ray
		Heart/Circulation
____	____	Chest Pain
____	____	Heart palpitations
____	____	Ankle swelling
____	____	Leg pain when walking

Now	Past	**Urinary**
____	____	Frequent Urination
____	____	Trouble holding urine
____	____	Trouble starting urine
____	____	Burning with Urination
		Nervous System
____	____	Fainting Spells
____	____	Convulsions (seizures)
____	____	Tremors
____	____	Numbness
____	____	Paralysis
		Females
____	____	Pregnancy
____	____	date of last period_________
____	____	# of pregnancies__________
____	____	# of live births____________
		Endocrine System
____	____	Dry skin
____	____	Cold intolerance
____	____	Thirst
____	____	Appetite change
		Allergy/Immune System
____	____	Hives
____	____	Chronic itching
____	____	Hay fever
____	____	Allergy work-up
		Heme/Lymph System
____	____	Easy breathing
____	____	Bleeding problems
____	____	Fatigue
____	____	Enlarged glands
		Stomach/Intestines
____	____	Heartburn/Indigestion
____	____	Frequent or bad stomach pain
____	____	Frequent or severe vomiting
____	____	Vomiting blood

Physician only: I have reviewed this note ______________________________

Physician only: Signature and date ______________________________