

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	Now	Past	Urinary
_____	_____	Noise exposure	_____	_____	Frequent Urination
_____	_____	Head injury or concussion	_____	_____	Trouble holding urine
_____	_____	Draining ears	_____	_____	Trouble starting urine
_____	_____	Painful ears	_____	_____	Burning with Urination
_____	_____	Hearing Loss			
_____	_____	Ringing in ears			Nervous System
_____	_____	Dizziness or loss of balance	_____	_____	Fainting Spells
_____	_____	Chronic facial pain	_____	_____	Convulsions (seizures)
_____	_____	Headaches	_____	_____	Tremors
_____	_____	Chronic nasal congestion	_____	_____	Numbness
_____	_____	Runny nose	_____	_____	Paralysis
_____	_____	Frequent nose bleeds			
_____	_____	Difficulty swallowing			Females
_____	_____	Hoarseness	_____	_____	Pregnancy
_____	_____	Throat pain	_____	_____	date of last period _____
_____	_____	Jaw pain	_____	_____	# of pregnancies _____
_____	_____	Chronic cough	_____	_____	# of live births _____
_____	_____	Tooth pain			
_____	_____	Loose teeth/bite problems			Endocrine System
_____	_____	Snoring	_____	_____	Dry skin
_____	_____	Double vision	_____	_____	Cold intolerance
_____	_____	Eye pain	_____	_____	Thirst
_____	_____	Change in vision	_____	_____	Appetite change
		General			Allergy/Immune System
_____	_____	Unexplained weight loss	_____	_____	Hives
_____	_____	Unexplained weight gain	_____	_____	Chronic itching
_____	_____	Night sweats	_____	_____	Hay fever
_____	_____	Joint pains and swelling	_____	_____	Allergy work-up
		Lungs			Heme/Lymph System
_____	_____	Coughing up blood	_____	_____	Easy breathing
_____	_____	Persistent wheezing	_____	_____	Bleeding problems
_____	_____	Shortness of breath	_____	_____	Fatigue
_____	_____	Abnormal chest x-ray	_____	_____	Enlarged glands
		Heart/Circulation			Stomach/Intestines
_____	_____	Chest Pain	_____	_____	Heartburn/Indigestion
_____	_____	Heart palpitations	_____	_____	Frequent or bad stomach pain
_____	_____	Ankle swelling	_____	_____	Frequent or severe vomiting
_____	_____	Leg pain when walking	_____	_____	Vomiting blood

Physician only: I have reviewed this note

Physician only: Signature and date
