MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE

9280 SE Sunnybrook Blvd. Suite 300, Clackamas, OR 97015
P: 503.233.5548 F: 866.663.1070

Adult Health History Form

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Primary Physician: _____

Main Reason for Today's Visit: _____

Preferred Pharmacy Name: _____ Location: _____

Personal Medical History: Please, indicate whether you have had any of the following medical problems:

□ Heart Disease:
Specify type: _____
□ Asthma/Lung Disease
□ Cancer (specify):_____
□ High Blood Pressure
□ Diabetes
□ Sleep Apnea
□ Other (specify):_____
□ Thyroid Problem
□ Acid Reflux
□ Bleeding Disorder

Surgical History: Please list all prior operations:

Procedure:	Date:	Procedure:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Medications: Prescription and non-prescription medications, vitamins, supplements, herbals, etc.

Medication:	Dose:	Medication:	Dose:	Medication:	Dose:
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

Allergies: Please list any allergies to medications, along with reaction:

Allergic to:	Reaction:	Allergic to:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____

Do you have environmental or food allergies? Yes No Have you ever had any allergy tests done? Yes No

If Yes, to what? _____

Family History: Please indicate if family members (parents, siblings, grandparents, aunts or uncles) have a history with the following:

□ Heart Disease
□ Stroke
□ Asthma/Lung Disease
□ Cancer (specify) _____
□ High Blood Pressure
□ Diabetes
□ Sleep Apnea
□ Hearing Loss
□ Thyroid Problem
□ Headaches
□ Bleeding Disorder
□ Problems with anesthesia

Occupation: _____

Do you smoke cigarettes? □ Never □Quit Date _____ □Current Smoker: packs/day_____# of years_____

Other Tobacco/Nicotine? □ Pipe □ Cigar □ Snuff □ Chew □ Vape Caffeine Intake: □ None □ Coffee/Tea/Soda - Cups/Day?____

Do you drink alcohol? □ No □ Yes # of Drinks/Week____ Do you use recreational drugs? □ No □ Yes - _____

Caffeine Intake: □ None □ Coffee/Tea/Soda – Cups/Day_____

Signature: _____ Date: _____ Relationship to patient: _____