DEMERA

ALLERGY ASTHMA & ENT CENTER

# ADULT MEDICAL HISTORY

Patient Name ____________________ DOB ____________ Date ____________

Age ________ Sex ________ Ht ________ Wt ________ BMI ________

Primary Physician ____________________ Referring Physician ____________________

Reason for Visit ________________________________________

**Medical History** (check box if applicable and explain):

☐ Cancer (list types & dates) ☐ High Cholesterol ☐ Neurologic Disease ☐ Stomach Problems

☐ Diabetes ☐ Jaundice / Hepatitis ☐ Pregnancy ☐ Thyroid Disease

☐ Epilepsy ☐ Lung Disease ☐ Reflux ☐ Ulcers

☐ Heart Attack (TB, Asthma, Pneumonia, CF) ☐ Sleep Apnea ☐ Other (explain)

☐ High Blood Pressure` ☐ Migraine Headaches ☐ Stroke

**Surgical History:** ________________________________________

________________________________________

**Current Medications/Dosage:** ________________________________________

________________________________________

**Allergies/Intolerances to Medications:** ________________________________________

________________________________________

**Family History (r**eference family member):

☐ Allergies ________ ☐ Asthma ________ ☐ Diabetes ________ ☐ Heart Attack ________

☐ Heart Disease ________ ☐ Hives ________ ☐ Hypertension ________ ☐ Stroke ________

**Social History:** Birthplace: ____________________ How long in local area ____________________

Smoking? YES / NO Years smoked ________ Packs per day ________ Year quit ________

Alcohol? YES / NO Number of years________ Amount daily or weekly ________

Occupation: ____________________ Number of children ________ Marital Status: S M D W

**Review of System** (check box if applicable recently):

**General:** ☐ Fever ☐ Weight Loss ☐ Loss of appetite ☐ Fatigue

**Eyes:** ☐ Visual impairment ☐ Cataracts ☐ Glaucoma ☐ Double vision ☐ Eye Injury

**ENT:** ☐ Dizziness ☐ Canker sores ☐ Hearing loss ☐ Ringing in the ears ☐ Loss of Smell ☐ Loss of Taste

**CV:** ☐ Irregular beat ☐ Palpitations ☐ Chest pains (angina) ☐ Foot/ankle swelling

☐ Leg pain ☐ Poor circulation in legs ☐ Varicose veins

**Resp:** ☐ Wheezing ☐ Cough ☐ Cough w/mucous or w/o shortness of breath ☐ Recurrent infections

**GI:** ☐ Heartburn/GERD ☐ Ulcer ☐ Black stools ☐ Rectal bleeding ☐ Diarrhea ☐ Constipation ☐ Pain

**GU:** ☐ Blood in urine ☐ Nausea/vomiting ☐ Recurrent infections ☐ Urinary tract problems

☐ Menstrual problems ☐ Menopause ☐ Prostate trouble

**MS:** ☐ Joint paint ☐ Autoimmune disease (lupus, etc.)

**Neuro:** ☐ Headaches ☐ Seizure disorder ☐ Brain injury ☐ Developmentally disabled/ Learning disability ☐ Fainting spells

**Integument:** ☐ Eczema ☐ Psoriasis ☐ Boils ☐ Acne ☐ Chronic Rashes

**Endocrine:** ☐ Polydipsia (always thirsty) ☐ Polyuria (frequent urination) ☐ Cold ☐ Hot ☐ Tremors

**Heme/Lymph:** ☐ Anemia ☐ Bleeding Disorder

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