

CROWN Otolaryngology Adult Intake Form Section 1

MEDICAL HISTORY Continued:

Stomach/Intestinal Disorder	Yes ___ No ___	
Skin Disorder	Yes ___ No ___	
Clotting Disorder	Yes ___ No ___	
Eye Disorder	Yes ___ No ___	
Psychiatric Disorder	Yes ___ No ___	
Urinary/Kidney Disorder	Yes ___ No ___	
Liver Disorder	Yes ___ No ___	
Orthopedic Disorder	Yes ___ No ___	
Cholesterol Disorder	Yes ___ No ___	
Neurologic Disorder	Yes ___ No ___	
Other	Yes ___ No ___	

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	Yes	No	NOTES
1. CONSTITUTIONAL			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
3. ENT/MOUTH			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
7. MUSCULOSKELETAL			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
8. SKIN			
Rash	<input type="checkbox"/>	<input type="checkbox"/>	

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9. NEUROLOGICAL	YES	NO	NOTES
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
10. PSYCHIATRIC			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
11. ENDOCRINE			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
12. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
13. ALLERGIC/IMMUNOLOGIC			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	

FAMILY HISTORY: Please indicate any major conditions/illnesses that your family members have had:

RELATIVE _____ **CONDITION & DESCRIPTION** _____ **LIVING (Y/N)** _____ **IF DECEASED, AT WHAT AGE?** _____

First Name

Mother: _____
First Name

Father: _____

Other: _____

SURGICAL HISTORY: List any surgeries you have had and the approximate date:

Have you had a blood transfusion Yes ___ No ___ ? If yes, when? _____

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____ Children? Yes ___ No ___ Their ages? _____

Do you exercise regularly? Yes ___ No ___ Describe your exercise routine: _____

Do you have pets in your home? Yes ___ No ___ Describe: _____ Health Care Proxy _____

Smoking: Currently? Yes ___ No ___ Previously? Yes ___ No ___ Years Smoked _____ Packs per day _____

Other tobacco or substance _____ Date stopped _____

Are/were you exposed to 2nd hand smoke at home or work? Yes ___ No ___ , If "Yes," explain _____

Other substances: Alcohol? Yes ___ No ___ Recreational Drugs? Yes ___ No ___

Describe use _____

Patient Signature _____ **Date** _____

FOR OFFICE USE ONLY:

CROWN-05-85-09 intake

The following sections were entered into CROWN by (sign initials next to the section(s) you entered):

All _____ Problems _____ Allergies _____ Medical Hx _____
 Surgical Hx _____ Family Hx _____ Social History _____

Physician Signature _____ **Date** _____