advanced
EAR, NOSE & THROAT
head and neck surgery

Randall S. Lomax D.O.

Adult History

Please answer each question by filling in the appropriate circle fully.

Do you have any medical problems?

- O Eye problems
- O Vision changes
- O Sinusitis
- O Allergies in the past
- O Ear problems
- O Nose problems
- O Throat/Neck problems
- O High blood pressure
- O Mitral valve prolapse
- O Heart Attack in the past
- O Asthma
- O COPD
- O Genitourinary problems
- O Migraine headaches
- O Seizures
- O Anxiety/Depression
- O Diabetes
- O Thyroid problems
- O Anemia
- O Blood cancer
- O Skin cancer
- O Breast cancer
- O Other, please list:_____
- O None

Please List all Medications that you are currently taking:_____
_____

Please List all Allergies to Medications and the reaction you have to them:_____
_____
_____

Please List all Surgeries:_____
_____

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Please answer each question by filling in the appropriate circle fully.

Does anyone in the family have any medical problems?

Mother	O Yes O No	If yes, please list:_____
Father	O Yes O No	If yes, please list:_____
Children	O Yes O No	If yes, please list:_____
Maternal Grand Mother	O Yes O No	If yes, please list:_____
Maternal Grand Father	O Yes O No	If yes, please list:_____
Paternal Grand Mother	O Yes O No	If yes, please list:_____
Paternal Grand Father	O Yes O No	If yes, please list:_____

Do you?

Drink Alcohol O Yes O No

If yes, amount: O 1 O 2 O 3 O 4 O per day O per week O per month

Smoke O Yes O No

If yes, amount: O 1 O 2 O 3

O packs/day O packs/week

For how long? O <5 yrs O 5-10yrs O 10-15 yrs O >15 yrs

Use Smokeless Tobacco O Yes O No

Use Recreational drugs O Yes O No

Are you around smoke O Yes O No

Are you Employed O Yes O No

Please List Occupation:_____

Have you experienced any of the following in the last 6 months?

weight change	O Yes O No
fever	O Yes O No
chills	O Yes O No
fatigue (feeling run down)	O Yes O No
hearing loss	O Yes O No
sore throat	O Yes O No
nose bleeds	O Yes O No
change in voice	O Yes O No
ringing in ears	O Yes O No
dizziness	O Yes O No
allergies	O Yes O No

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Have you experienced any of the following in the last 6 months?

chest pain	O Yes O No
irregular heart rhythm	O Yes O No
take coumadin/blood thinners	O Yes O No
nausea	O Yes O No
vomiting	O Yes O No
diarrhea	O Yes O No
difficulty swallowing	O Yes O No
heartburn	O Yes O No
diabetes	O Yes O No
thryoid disease	O Yes O No
cold intolerance	O Yes O No
heat intolerance	O Yes O No
headache	O Yes O No
memory loss	O Yes O No
difficulty walking	O Yes O No
blurring of vision	O Yes O No
cough	O Yes O No
wheezing	O Yes O No
shortness of breath	O Yes O No
runny nose	O Yes O No
itchy eyes	O Yes O No
stuffy nose	O Yes O No
easy bruising	O Yes O No
anemia	O Yes O No
skin rashes	O Yes O No
skin lesions	O Yes O No
rheumatoid arthritis	O Yes O No
lupus	O Yes O No