Cheryl Varner, MD
Board Certified Otolaryngologist
1416 West 5th Street
Sheridan, WY 82801
Phone: (307) 675-4646
Fax: (307) 675-4645

BIG HORN EAR, NOSE & THROAT
Hometown Care for Your Family

ADULT MEDICAL HISTORY FORM

Date: _____ Preferred Pharmacy:_____

Name: _____ Age: _____

Referring Physician's name (if applicable) or Primary Care Physician:
_____
_____

Briefly state why you are being seen today **(Chief Complaint)**
_____
_____

Review of Symptoms:
Check all symptoms that you are **currently** or have **recently** experienced:

__Unexplained Weight Loss
__Change in Vision
__Dizziness
__Chest Pain
__Diarrhea
__Blood in Stool
__Muscle or Joint Pain
__Fevers/Night Sweats
__Heat/Cold Intolerance
__Shortness of Breath
__Bleeding/Bruising Easily
__Constipation
__Pain with Urination
__Numbness in Extremities
__Other: _____

Any possibility you are currently pregnant?	YES	NO
Is there anything else we should know about your health that is not covered by these questions?	YES	NO

If yes, please explain:

Past History:
Check (√) any current or past **medical problems:**

__Nasal Allergies/Hay Fever	__Heart Trouble or murmur	__High Blood Pressure
__Stroke	__Seizures	__Mental Health Problems
__Stomach/Duodenal Ulcers	__Kidney Problems	__Hepatitis/Liver Disease
__Bleeding Disorders	__Asthma/Lung Disease	__Thyroid Disease
__Tumor/Cancer	__Anemia	__Tuberculosis
__Diabetes	__Muscle, Joint/Bone	__Glaucoma

__Other:_____
_____

---OVER---

Are you **allergic** to any medications? YES NO

If yes, please list the medication(s) and the reaction (rash, difficulty breathing, etc.): _____
_____

List all current **medications** including vitamins and herbal supplements:

Medication Name	Dose	Reason for Taking

List all previous **operations**, including year performed:
_____
_____
_____

Family History:
Circle any of the following diseases that run in your family and who has them:

Diabetes	Mother	Father	Sister	Brother
Heart Disease	Mother	Father	Sister	Brother
High Blood Pressure	Mother	Father	Sister	Brother
Early Hearing Loss	Mother	Father	Sister	Brother
Cancer	Mother	Father	Sister	Brother

Social History:
Do you use tobacco products now or have you in the past? YES NO
If cigarettes, packs per day_____ Number of years_____
Are you still using tobacco products? YES NO

Do you drink alcohol? YES NO
If yes, how many drinks per week?_____
Have you ever been told you have an alcohol problem? YES NO

What is your current or former occupation?_____
Are you retired? YES NO
Are you disabled? YES NO
If yes, why are you disabled?_____

<u>Nurse Use Only</u>
Vital Signs

Height: _____
Weight: _____
B.P.: _____
Temp: _____
Pulse: _____ Surgery Date_____
Resp: _____
SpO2 _____