Otolaryngology – Head and Neck Surgery Consultation
St. Joseph Health Medical Group – Humboldt
707-444-8863

Date: ______________________ **Patient Name:** ______________________ **Date of Birth:** ____________

Reason(s) for Visit:

Primary Care Provider:

Preferred Pharmacy Information:
Name:
Location:

Preferred Hospital:

Review of Systems:

Constitutional:	☐ fevers ☐ night sweats ☐ weight loss ☐ weight gain ☐ daytime fatigue
Eyes:	☐ visual loss ☐ double vision ☐ dry eyes ☐ droopy eyelids ☐ frequent tearing
Ears:	☐ hearing loss ☐ dizziness ☐ ringing in the ears ☐ ear pain ☐ ear drainage ☐ pressure
Nose:	☐ post-nasal drainage ☐ loss of smell ☐ nasal obstruction ☐ nose bleeds
Mouth:	☐ sores ☐ tooth problems ☐ salivary gland problems ☐ dry mouth ☐ jaw pain
Throat:	☐ snoring ☐ hoarseness ☐ difficulty swallowing ☐ pain with swallowing ☐ sore throat ☐ neck mass
Cardiovascular:	☐ chest pain ☐ irregular heart beat ☐ heart murmur ☐ dizzy when standing up quickly
Respiratory:	☐ cough ☐ shortness of breath ☐ wheezing ☐ coughing up blood ☐ hoarseness
Gastrointestinal:	☐ nausea ☐ vomiting ☐ heartburn or acid reflux ☐ abdominal pain ☐ diarrhea ☐ constipation
Genitourinary:	☐ difficulty with urination ☐ pain with urination ☐ loss of bladder control ☐ blood in urine
Musculoskeletal:	☐ weakness ☐ joint pain ☐ back pain ☐ neck pain ☐ numbness of feet
Integumentary:	☐ rashes ☐ skin lesions ☐ scars ☐ hair loss ☐ dry skin
Neurological:	☐ seizures ☐ facial pain ☐ headaches ☐ numbness ☐ tremor ☐ memory problems
Psychiatric:	☐ depression ☐ anxiety ☐ suicidal thoughts ☐ claustrophobia ☐ hyperactivity
Endocrine:	☐ diabetes ☐ thyroid problems ☐ heat intolerance ☐ cold intolerance ☐ menopause
Hematologic:	☐ enlarged lymph nodes ☐ easy bruising ☐ abnormal bleeding ☐ anemia
Allergy:	☐ hives ☐ dermatitis ☐ anaphylaxis ☐ itchy eyes ☐ watery eyes ☐ sneezing

Past Medical History:

Constitutional:	☐ cancer (type)________________________ ☐ lymphoma ☐ chemotherapy ☐ radiation treatment
Eyes:	☐ glaucoma ☐ blindness ☐ cataract ☐ eyeglasses
Ears:	☐ otosclerosis ☐ Tympanic membrane perforation ☐ Meniere's disease ☐ cholesteatoma
Nose:	☐ chronic sinusitis ☐ nasal polyps ☐ deviated nasal septum ☐ broken nose
Mouth:	☐ sjogren's syndrome ☐ salivary gland stones ☐ cavities
Throat:	☐ Zenker's diverticulum ☐ obstructive sleep apnea ☐ vocal cord paralysis ☐ recurrent tonsillitis
Cardiovascular:	☐ heart attack ☐ cardiac stent ☐ pacemaker ☐ heart failure ☐ heart murmur ☐ high blood pressure
Respiratory:	☐ asthma ☐emphysema ☐COPD ☐ cystic fibrosis ☐ pneumonia ☐ tuberculosis
Gastrointestinal:	☐ ulcer ☐ acid reflux ☐ inflammatory bowel disease ☐ esophageal varices ☐ cirrhosis
Genitourinary:	☐ prostate enlargement ☐ incontinence ☐ frequent urinary tract infections ☐ warts
Musculoskeletal:	☐ rheumatoid arthritis ☐ osteoarthritis ☐ peripheral neuropathy
Integumentary:	☐ skin cancer ☐ dermatitis ☐ psoriasis
Neurological:	☐ seizure ☐ stroke ☐ Parkinson's ☐ head injury ☐ migraine ☐ multiple sclerosis ☐ meningitis
Psychiatric:	☐ depression ☐ anxiety ☐ suicidal attempts ☐ alcoholism ☐ autism ☐ schizophrenia
Endocrine:	☐ diabetes ☐ hypothyroidism ☐ hyperthyroidism ☐ thyroiditis ☐ Grave's disease
Hematologic:	☐ bleeding disorder ☐ anemia ☐ blood transfusion ☐ hepatitis ☐ HIV/AIDs
Allergy:	☐ eczema ☐ angioedema ☐ immunotherapy ☐ allergic rhinitis

Any Other Medical Problems:
1.
2.
3.

Vaccination Status: ☐ **received childhood vaccines** ☐ **flu shot** ☐ **have not received vaccines**

Patient Name:

Date of Birth:

For Females: any chance you may be pregnant? ☐ YES ☐ NO Last Menstrual Period: _____________

Past Surgical History: (name, year, surgeon):
1.
2.
3.
4.
5.

Allergies:

Medications	☐ no	☐ yes	which ones and describe the reaction:
IV contrast	☐ no	☐ yes	reaction:
Latex	☐ no	☐ yes	reaction:
Shellfish	☐ no	☐ yes	reaction:
Foods	☐ no	☐ yes	which foods and describe the reaction:
Metal Allergy (Nickel)	☐ no	☐ yes	reaction:

Medications: (Name, Dose, Frequency)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Family History: (indicate the relationship of the family member)
- ☐ Cancer
- ☐ Heart Disease
- ☐ Migraine
- ☐ Hearing loss
- ☐ Bleeding disorder
- ☐ Problems with anesthesia

Social History:

Occupation?	☐ Student	☐ Other: ___________________________________	
Patient or Family members attend Daycare?	☐ YES	☐ NO	
Pets in household?	☐ YES	☐ NO	If so, what kind? ____________________
Tattoos?	☐ YES	☐ NO	
Second hand smoke?	☐ YES	☐ NO	
Firearm use?	☐ YES	☐ NO	

If the patient is a minor, are there any special custody circumstances? ____

Substance Use:

How many alcoholic drinks per week? ☐ none ☐ 1-5 ☐ 6-10 ☐ 10+

Cigarettes:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
Cigars:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
Chewing tobacco:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
Marijuana:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
Heroin:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
Cocaine:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
Methamphetamine:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______
IV drugs:	☐ Never	☐ Started (year) _______	☐ Quit (year) _______

Have you had any of the following studies done related to the reason for your visit?

Laboratory:	☐ Blood work	☐ Allergy testing	☐ Biopsy	
Imaging:	☐ X-ray	☐ CT scan	☐ MRI	☐ PET scan
Other:	☐ Previous hearing tests			