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**New Adult Health Assessment**

* Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographics:**

* Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Past medical history:** | | | |
|  | Diabetes |  | COPD |
|  | Hypertension |  | Asthma |
|  | Heart Attack |  | Eczema |
|  | Stroke |  | Gastroesophageal Reflux/Heartburn |
|  | Atrial fibrillation/ Irregular Heart Beat |  | Kidney disease |
|  | Obstructive sleep apnea |  | Cancer- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Glaucoma: open closed |  | Hypothyroidism |

**Other medical history**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bleeding tendency:**

* Are you on **blood thinners** (ex: Aspirin, Plavix, warfarin, Clopidogrel)?

1. No 2. Yes

**If Yes**, Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indications (why are you taking it):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Personal history** of bleeding tendency disease (ex. hemophilia, low platelets, leukemia)
* **Family history** of **bleeding tendency**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you take **Advil frequently**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**

|  |  |
| --- | --- |
| **ENT surgeries** | **Date** |
| Sinus surgery |  |
| * *Septoplasty* (straightening of the septum) |  |
| * *Turbinoplasty* (reduction of turbinates due to swelling) |  |
| * *Endoscopic Sinus Surgery* (remove blockage/enlarge sinus openings) |  |
| * *Rhinoplasty* (plastic surgery of the nose) |  |
| *Tonsillectomy* (removal of tonsils) |  |
| *Adenoidectomy* (removal of adenoids) |  |
| *Ventilation tube* (Ear tubes) |  |
| Other ENT surgeries |  |

**Other surgical history and dates**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anesthesia-***If you had history of surgery under general anesthesia.*

Have you had **any problem** with anesthesia? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or **family history** of anesthesia related problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

* **Drug allergy**: Drug name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Latex Allergy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Environmental Allergies** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Mold exposure** at home or house? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications:** | | | |
| **Prescription Medications** | **Dosage** | **Frequency** | **Reason for taking** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Over the counter medications:** |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Vitamins** |  |  |  |
|  |  |  |  |
| **Herbal Supplement** |  |  |  |
|  |  |  |  |
| **See attached list (if needed)** |  |  |  |

**Social History:**

**Smoking: (circle what applies)**

1. No
2. Yes: How long have you been smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Quit: When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_

For how long have you smoked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recreational medication: (circle what applies)**

1. No
2. Yes: What is the name of recreational medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the Last dose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for drug abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol:**

1. How often do you have a drink containing alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many standard drinks containing alcohol do you have on a typical day? \_\_\_\_\_\_\_\_\_
3. How often do you have six or more drinks on one occasion? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Women only:**

Are you:

1. Pregnant now? B) Planning to get pregnant? C) Nursing a child

Birth control methods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you completing this health assessment☺**