

Dubuque ENT, Head and Neck Surgery, PC
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Name: _____
DOB: ___/___/___ age: _____

Today's date: ___/___/___

Adult Patient Medical History

What is the main reason for today's visit?

How long has this been a problem? ___ Hours ___ Days ___ Weeks ___ Months ___ Years

Please list any other complaints you want to discuss today

Did a doctor refer you here today? Yes No If so, who? _____

Who is your primary care physician (internist, family practitioner)? _____

Have you ever taken antibiotics, over the counter meds or other medications for this problem? Yes No

If so, please list. _____

Have X-rays, CT scans, MRI scans or allergy tests been obtained for this problem? Yes No

If so, when and where were they taken? _____

Past Medical History

Please write down any previous surgeries and the approximate dates

Do you have any **medical problems** that require regular visits or medications? (Please check)

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Reflux/GERD | <input type="checkbox"/> Skin rashes/diseases |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Apnea (CPAP) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer – type? _____ | <input type="checkbox"/> Leukemia/Lymphoma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver/Kidney disease | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lupus | _____ |
| <input type="checkbox"/> Eye disease | <input type="checkbox"/> Migraine headache | |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Muscle/bone problems | |

Have you had a heart attack, congestive heart failure, chest pain, heart surgery, angioplasty, or cardiac stent? Yes No If so when, and who is your cardiologist? _____

List all medications, including aspirin, herbal medicines, over the counter medicines and vitamins, you take on a regular basis with doses:

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO:

Family History Please list any relatives that have or have had any of the following:

Hearing loss ___ How related _____ Cancer ___ How related _____
Diabetes ___ How related _____ Asthma ___ How related _____
Heart trouble ___ How related _____ Allergies ___ How related _____
Bleeding or clotting problems ___ How related _____

Social History

Have you ever been a smoker? Yes No If yes, ____ packs per day , for _____ years

If you have quit, how long ago? _____

Do you use smokeless tobacco? Yes No

Do you drink alcohol? Yes No If yes, how many drinks per day ____ week ____ month ____

Who lives at home with you? _____

Review of Systems Please circle any medical problems you are currently having.

Body as a Whole

Fatigue
Fevers
Weight loss
Weight gain
Trouble sleeping

Head

Headache
Facial pain

Eyes

Blurred vision
Glaucoma
Cataracts
Itching
pain

Ears

Drainage
Decreased hearing
Fluid
Fullness
Recurrent infection
Pain
Imbalance
Dizziness
Ringing/noise
Noise exposure

Nose

Drainage
Stiffness
Changes in smell
Polyps
Frequent colds
Frequent sinus infection
Broken Nose
Bleeding
Frequent colds

Allergies

Sneezing
Pets in home
Spring
Summer
Fall
Winter
Foods

Throat

Drainage
Pain
Tonsillitis
Bad breath
Snoring
Large tonsils
Noisy breathing
Throat clearing
Hoarseness
Cough

Neck

Large glands
Pain
Cyst or lump
Thyroid problems

Lungs

Asthma
Wheezing
Bronchitis
Bloody cough
Emphysema/COPD

Heart

Murmur
Surgery
Extra beats
Chest pain
Heart attack
Prolapsed valve

Stomach

Diarrhea
Constipation
Cramps
Heartburn
Ulcer

Muscle/Bones

Joint pain
Joint swelling
Weakness
Back Pain

Urinary Tract

Frequency
Burning
Stones
Bleeding
Infections

Neurological

Seizures
Numbness
Tingling
Paralysis
Tremor

Psych

Depression
Anxiety

Skin

Eczema
Itching
Hives
Rash
Moles