**Dubuque ENT, Head and Neck Surgery, PC**
**Craig C Herther, MD, FACS**
**Thomas J Benda, Jr, MD, FACS**
**Greg J White, MD, FACS**
**Dan J Givens, MD**

**Name:**_____
**DOB:____/____/____ age:**_____
**Preferred Pharmacy/Location**_____
**Email Address**_____
**Primary Care Physician**_____

**Todays 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 (internest, family practicioner)? _____

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)

__Allergies
__Anemia
__Anxiety
__Arthritis
__Asthma
__Bleeding problems
__Cancer – type?_____
__Diabetes
__Dizziness
__Eye disease
__Emphysema/COPD
__Gastrointestinal problems
__Reflux/GERD
__Heart Disease
__Hepatitis
__High Blood Pressure
__HIV/AIDS
__Leukemia/Lymphoma
__Liver/Kidney disease
__Lupus
__Migraine headache
__Muscle/bone problems
__Sinus
__Skin rashes/diseases
__Sleep Apnea (CPAP)
__Strokes
__Thyroid problems
__Tuberculosis
__Other:
_____
_____

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:

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OVER

## 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
Stuffiness
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