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:___/___/____

Child/Minor 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
_____
_____

Who is the child's pediatrician or family doctor?_____

Has your child 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

Was your child born full term? Yes No
Any problems with the child's growth and development? Yes No
If yes, please explain _____

Please write down any **previous surgeries** and the approximate dates
_____
_____
_____

Does your child have any **medical problems** that require regular visits to the doctor? (Please check):

__ADD/ADHD	__Ear infections	__Migraine headache
__Anemia	__Eye problems	__Muscle/bone problems
__Asthma/Reactive Airway disease	__Gastrointestinal problems	__Reflux/heartburn
__Bleeding problems/bruising	__Heart murmur	__Sinus problems
__Cancer	__Liver/kidney disease	__Skin disease/rash
__Leukemia/lymphoma	__Diabetes	__Thyroid gland problems

Other:_____

List all medications, including aspirin, other the counter medicines and vitamins, your child takes regularly:
_____
_____

LIST ANY MEDICATIONS OR SUBSTANCES YOUR CHILD IS ALLERGIC TO:_____

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

Who lives at home with the patient? _____
Does anyone at home smoke? Yes No
Are there pets in the home? Yes No
Is the child in school or day care ? Yes No

Review of Systems Please circle any problems the child is currently having.

Body as a Whole
Fatigue
Fevers
Weight loss
Weight gain

Head
Headache
Facial pain
Flat spot

Eyes
Mattering
Redness
Dark circles

Ears
Drainage
Decreased hearing
Fluid
Recurrent infection
Pain
Speech delay
Imbalance/not walking
Dizziness

Nose
Drainage
Stuffiness
Bad smell
Polyps
Foreign object
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

Heart
Murmur
Surgery
Extra beats

Stomach
Diarrhea
Constipation
Cramps
Heartburn

Muscle/Bones
Joint pain
Joint swelling
Weakness

Urinary Tract
Frequency
Burning
Stones

Neurological
Seizures
Numbness
Paralysis
Tremor

Psych
Attention deficit
Depression
Anxiety

Skin
Eczema
Itching
Hives
Rash
Moles