DUBUQUE ENT HEAD & NECK SURGERY, PC

Appointment date ___/___/_____ Time ___:___ Dr._____

Name:_____ DOB:____/____/____ Email Address_____

Pharmacy/Location_____ Employer Name:_____

Insurance Name_____ Insurance ID#_____

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 Surgical History

Please write down any previous surgeries and the approximate dates, if more room is needed, please attach separate sheet.

_____

_____

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 medications and dose, including aspirin, herbal medicines, over the counter medicines and vitamins, you take on a regular basis.

_____

_____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO:

Medication_____ Reaction_____

Medication_____ Reaction_____

Medication_____ Reaction_____

Family History

Please list any relatives that have or have had any of the following (maternal or paternal)

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___If **YES,** less than 1 can/week___,1 can/week___,1 can/day___,1can last few days
Do you drink alcohol? Yes___ No___ If **YES**, how many drinks per day____ week_____ month_____
Who lives at home with you? _____
How many children did/do you have – sons____, daughters ____
How many siblings did/do you have – brothers____, sisters____

Review of Systems

Please circle any medical problems you are currently having.

Body as a Whole
Fatigue
Fevers
Weight loss
Weight gain
Trouble sleeping
Headache
Facial 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

Neck
Large glands
Pain
Cyst or lump
Thyroid problems

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

Allergies
Sneezing
Pets in home
Spring allergies
Summer
Fall
Winter
Foods

Eyes
Blurred vision
Glaucoma
Cataracts
Itching
Pain
Tearing down face

Lungs
Asthma
Wheezing
Bronchitis
Bloody cough
Emphysema/COPD

Heart
Murmur
Surgery
Extra beats
Chest pain
Heart attack

Stomach/GI
Diarrhea
Constipation
Cramps
Heartburn
Reflux
Swallowing problems

Urinary Tract
Frequency
Burning
Stones
Bleeding
Infections

Muscle/Bones
Joint pain
Joint swelling
Weakness
Back pain

Skin
Eczema
Itching
Hives
Rash
Moles
Non-healing sore
Scar

Neurological
Seizures
Numbness
Tingling
Paralysis
Tremor

Psych
Depression
Anxiety
Attention Deficit