DUBUQUE ENT HEAD & NECK SURGERY, F
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Appointment date//	Time:	Dr	
Name:	_ DOB://	_ Email Address	
Pharmacy/Location	Employer Name:		
Insurance Name Insurance ID#			
Adult Patient M What is the main reason for today's visit?	Medical History		
How long has this been a problem?Hours Please list any other complaints you want to discuss too		Months Years	
Did a doctor refer you here today? Yes No If so, w Who is your primary care physician (internist, family p Have you ever taken antibiotics, over the counter meds If so, please list.	vho? ractitioner)? or other medications fo	r this problem? Yes No	
Have X-rays, CT scans, MRI scans or allergy tests been If so, when and where were they taken?			
Past Surgical History Please write down any previous surgeries and the appro-	oximate dates, if more re	oom is needed, please attach separate sheet.	
AnemiaRefle	ar visits or medications? rointestinal problems ux/GERD t Disease	(Please check) Sinus Skin rashes/diseases Sleep Apnea (CPAP)	

Do you have any <b>medical problems</b> that requir	e regular visits or medications? (Please check)	
_Allergies	Gastrointestinal problems	Sinus
Anemia	Reflux/GERD	Skin rashes/diseases
Anxiety	Heart Disease	_Sleep Apnea (CPAP)
Arthritis	Hepatitis	Strokes
Asthma	High Blood Pressure	Thyroid problems
Bleeding problems	HIV/AIDS	Tuberculosis
Cancer – type?	Leukemia/Lymphoma	Other:
Diabetes	Liver/Kidney disease	
Dizziness	Lupus	
Eye disease	Migraine headache	
Emphysema/COPD	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 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	r How related	 
Diabetes	How related	Asthm	a How related	
Heart trouble	How related	Allerg	ies How related	 

Social History       Yes_No_IFYES, packs per day, foryears         **Toy ou use sanoker?       Yes_No_IFYES, less than 1 can/week_1 1 can/week_m, lean hast few days         Do you drive showe quit, how long ago?       IFYES, less than 1 can/week_1 1 can/week_m, lean hast few days         Do you drive showe quit, how long ago?       IFYES, less than 1 can/week_1 1 can/week_m, lean hast few days         Do you drive showe quit, how long ago?	Bleeding or clotting problems How r	elated	PAGE 1
Have you even been a sunoker?       Yes       No       If YES,	Social History		FAGE I
Do you use smokeless tobacco? Yes_No_If YES, less than I can/wekI can/wekI can/dwyI can last few days Do you driva dacoho? Yes_No_If YES, how many drinks per daywekkmonth Who lives a thome with you? How many children diddo you have - botthers,, siters How many siblings diddo you have - botthers,, siters <b>Body as a Whole</b> Throat Stomach(GI Parlinge Diarrhea Fatigue Drainage Diarrhea Fevers Pain Constipation Weight gain Bad breath Heartbourn Trouble sleeping Snoring Reflux Headache Large tonsils Swallowing problems Facial pain Movies of the store of the store of the store facial pain Movies of the store of the store of the store Drainage Cough Burning Decreased hearing Urinary Tract Facial pain Movies of the store of the store of the store Drainage Cough Burning Decreased hearing Field Fullocs Snoczing Infections Recourcent infection Pets in home Pain Spring allorgics Muscel/Bones Involate Store Foods Back pain Noise cryosure Foods Back pain Noise cryosure Foods Back pain Noise cryosure Foods Back pain Storing Resease Fall Joint swelling Pray Store Store Stuffiness Glaucoma Itching Howes Store Stuffiness Glaucoma Itching Howes Frequencial instruction Fere Store Stuffiness Glaucoma Itching Carma Stuffiness Glaucoma Itching Changes in smell Cataracts Hives Polyps Itching Rash Frequent colds Pain Moles Frequent situs infection Tearing down face Non-healing sore Scar Bleeding Store Broken nose Store Stariness Fall Shore Stuffiness Blaured vision Fere Scar Bleeding Store Stariness Fall Moles Frequent situs infection Tearing down face Non-healing sore Scar Bleeding Store Broken nose Sto	Have you ever been a smoker? Yes N	No If <b>YES</b> , packs per day , fo	or years
Do you drink alcohol? Yes_Now many drinks per dayweekmonth We lowe and none with you?	**If you have quit, how long ago?	If VES loss than 1 con/work 1 con	n/wash 1 con/dow 1 con last forw dows
Who lives at home with yod?	Do you drink alcohol? Yes No	If YES, less than I can/week, I can If YES, how many drinks per d	av week month
How many sublings divide you have - brothers sisters Recircle of Systems Please circle any modelical problems you are currently having. Body as a Whole The product of the system of t	Who lives at home with you?		
How many sublings diddo you have - brothers sisters Review of Systems Please circle any modelian problems you are currently having: Pady as a Whole The product of the system is t	How many children did/do you have - sons	, daughters	
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Prolapsed valve