

DUBUQUE ENT HEAD & NECK SURGERY, PC

Appointment date ___/___/___ Time ___:___ Dr. _____
Name: _____ DOB: ___/___/___
Pharmacy/Location _____ Email Address: _____
Insurance Name _____ Insurance ID# _____

Father (Full Name) _____ Mother (Full Name) _____
Birthdate ___/___/___ SS# _____ Birthdate ___/___/___ SS# _____
Address: _____ Address: _____
Phone (H) _____ (W) _____ Phone (H) _____ (W) _____
(Cell) _____ (Cell) _____
Employer _____ Marital Status _____ Employer _____ Marital Status _____

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 _____

Past Surgical History

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

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

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Migraine headache
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Muscle/bone problems
<input type="checkbox"/> Asthma/Reactive Airway disease	<input type="checkbox"/> Gastrointestinal problems	<input type="checkbox"/> Reflux/heartburn
<input type="checkbox"/> Bleeding problems/bruising	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver/kidney disease	<input type="checkbox"/> Skin disease/rash
<input type="checkbox"/> Leukemia/lymphoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid gland problems

Other: _____

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

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

Who lives at home with the patient? _____ Brothers: _____ Sisters: _____
Does anyone in the home smoke? Yes _____ No _____
Are there pets in the home? Yes _____ No _____ If yes, what animals _____
Is the child in day care? Yes _____ No _____ School/Elem _____ Middle _____ High School _____

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

Body as a Whole

Fatigue
Fever
Weight loss
Weight gain
Headache
Facial pain
Flat spot

Ears

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

Nose

Drainage
Stiffness
Bad smell
Polyps
Foreign object
Bleeding
Frequent colds

Neck

Large glands
Pain
Cyst or lump

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

Mattering
Redness
Dark circles

Lungs

Asthma
Wheezing
Bronchitis

Heart

Stomach/GI

Diarrhea
Constipation
Cramps
Heartburn
Reflux

Urinary Tract

Frequency
Burning
Stones

Muscle/Bones

Joint pain
Joint swelling
Weakness

Skin

Eczema
Itching
Hives
Rash
Moles

Neurological

Seizures
Numbness
Paralysis
Tremor

Psych

Depression

Thyroid problems

Murmur
Surgery
Extra beats

Anxiety
Attention deficit

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