Dubuque ENT
HEAD & NECK SURGERY

ADULT PATIENT MEDICAL HISTORY

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 a 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 doses, including aspirin, herbal medicines, over-the-counter medicines and vitamins, that you take on a regular basis. ____

____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO:

Medication: ______________________ Reaction: ______________________

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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 one can/week _______ , one can/week _______ , one can/day ____________ , one can 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 check 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
- ☐ Prolapsed valve

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
- ☐ Nonhealing sore
- ☐ Scar

Neurological
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis
- ☐ Tremor

Psych
- ☐ Depression
- ☐ Anxiety
- ☐ Attention deficit