Dubuque ENT
HEAD & NECK SURGERY

# ADULT PATIENT DEMOGRAPHIC

First Name: _____ Last Name: _____ Middle Initial: _____

DOB: _____ Sex: _____ SS#: _____

Address: _____

Home Phone: _____ Cellphone: _____ Work Phone: _____

Email: _____ Pharmacy/Location: _____

Employer: _____ Marital Status: _____

Primary Care Provider: _____

Name of Patient or Guardian Completing Form: _____

Signature of Patient or Guardian Completing Form: _____

Date: _____

**DUBUQUE ENT HEAD & NECK SURGERY**
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# ADULT PATIENT MEDICAL HISTORY

Appointment date: _____ Time: _____ Dr. _____

Name: _____ DOB: _____

## 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)

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? _____

☐ 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: _____

**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: _____

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 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