

ENT
CLINIC
OF IOWA, P.C.

Today's Date: _____ Patient's Name: _____

Birth date: _____ Age: _____ Occupation: _____

Referring Physician or Family Physician: _____

Date of last physical exam: _____ Pharmacy: _____

Please list any allergies you may have to medications: _____

What medications are you currently taking? _____

List your past illnesses: _____

Were you hospitalized for any of these illnesses? If so, please give approximate date and problem: _____

List your past surgeries: _____

Are you pregnant? Yes / No If so, how far along? _____

What is your current weight? _____ Weight 1 year ago: _____ Maximum weight: _____ When: _____

Do you smoke? Yes / No (circle one) How much per day? _____ How many years? _____

When did you quit? _____ Alcohol Consumption: (circle one) daily occasional social none

Do you have or have you had any of the following: (please circle yes or no by each item)

Cardiovascular:

High blood pressure	yes/no	Chest pain	yes/no
Low blood pressure	yes/no	Arrhythmia (irregular heartbeat)	yes/no
Coronary artery disease	yes/no	Rheumatic fever	yes/no
Heart Surgery (date) _____		Angioplasty (date) _____	
Other _____		High cholesterol	yes/no

Pulmonary:

Chronic obstructive lung disease	yes/no	Chronic cough	yes/no
Pneumonia	yes/no	Coughing up blood	yes/no
Asthma	yes/no	Shortness of breath	yes/no
Other _____		walking several blocks	yes/no
		one flight of stairs	yes/no
		on lying down?	yes/no

Earaches / ear pain	yes/no	Pain behind eyes	yes/no
Double / blurred vision	yes/no	Other _____	
Psychiatric:			
Mental illness	yes/no	Other _____	
Anxiety	yes/no	_____	
Depression	yes/no	_____	
Past Illness:			
German Measles	yes/no	Hepatitis	yes/no
Mumps	yes/no	AIDS	yes/no
Syphilis / Gonorrhea	yes/no	Tuberculosis	yes/no
Cancer (if so, what type?) _____		Other _____	

Family History of the Patient:

Father (circle one)	Living / Deceased	Age: _____	Cause of death: _____
Mother (circle one)	Living / Deceased	Age: _____	Cause of death: _____
Brother (circle one)	Living / Deceased	Age: _____	Cause of death: _____
Brother (circle one)	Living / Deceased	Age: _____	Cause of death: _____
Sister (circle one)	Living / Deceased	Age: _____	Cause of death: _____
Sister (circle one)	Living / Deceased	Age: _____	Cause of death: _____

Has any immediate family member had any of the following? (Please circle all that apply)

Cancer (what type?) _____	Diabetes	Yes / No
High blood pressure	Heart Trouble	Yes / No
Tuberculosis	Hemophilia	Yes / No
Stroke	Epilepsy	Yes / No
Early hearing loss	Problems with anesthesia	Yes / No

Please give any other information that may be helpful in your treatment of care today.

*****Please note*****

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

FOR OFFICE USE ONLY

Physician's initials after review

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____