IOWA ENT CENTER PLLC

ADULT HISTORY & PHYSICAL

Today's date: _____ /_____ /_____ **Patient name:** _____

Birth date: _____ /_____ /_____ **Age:** _____ **Occupation:** _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Referring physician or family physician: _____

Date of last physical exam: _____ /_____ /_____ **Pharmacy:** _____

Medication allergies: _____

Current medications: _____

List your past illnesses: _____

Were you hospitalized for any of these illnesses? ☐ Yes ☐ No

If so, please give approximate date and problem: _____

List your past surgeries: _____

Current weight: _____ **Weight one year ago:** _____ **Maximum weight:** _____ **When?** _____

History of tobacco use? ☐ Yes, currently ☐ Yes, formerly ☐ No, never

How much? _____ Quit date: _____ /_____ /_____

History of vaping? ☐ Yes, currently ☐ Yes, formerly ☐ No, never Quit date: _____ /_____ /_____

Alcohol consumption: ☐ None ☐ Occasionally ☐ Socially ☐ Daily

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

Do you have or have you had any of the following?

Cardiovascular

High blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No
Heart surgery (date)	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Arrhythmia (irregular heart beat)	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Angioplasty (date)	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No

Other: _____

Pulmonary

Chronic obstructive lung disease	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Walking several blocks	☐ Yes	☐ No
One flight of stairs	☐ Yes	☐ No
On lying down	☐ Yes	☐ No

Other: _____

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Do you have or have you had any of the following?

Upper respiratory

Nasal septal deformity	☐ Yes	☐ No
Hay fever/allergies	☐ Yes	☐ No
Chronic sinusitis	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
Sinus headaches	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Change in voice	☐ Yes	☐ No
Change in smell	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Wake up frequently	☐ Yes	☐ No
Stop breathing during sleep	☐ Yes	☐ No

Other: _____

Constitutional

Fevers	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No

Other: _____

Neurological

Stroke/TIA	☐ Yes	☐ No
Bell's palsy	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No
Head injury	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Facial pain/paralysis	☐ Yes	☐ No
Weakness/paralysis	☐ Yes	☐ No
Insomina	☐ Yes	☐ No

Other: _____

Eye/ear

Otitis media (ear infections)	☐ Yes	☐ No
Tinnitus (ringing in ears)	☐ Yes	☐ No
Ménière's disease	☐ Yes	☐ No
Ear drainage	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Earaches/ear pain	☐ Yes	☐ No
Double/blurred vision	☐ Yes	☐ No
Pain behind eyes	☐ Yes	☐ No

Other: _____

Genitourinary

Kidney stones	☐ Yes	☐ No
Bladder/kidney infections	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Difficult urination	☐ Yes	☐ No

Other: _____

Musculoskeletal

Joint replacement	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Broken bones	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No

Other: _____

Gastrointestinal

Ulcers	☐ Yes	☐ No
Lesion of GI tract	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Stomach pain	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No

Other: _____

Endocrine/immune system

Diabetes	☐ Yes	☐ No
Hyperthyroidism (overactive)	☐ Yes	☐ No
Hypothyroidism (underactive)	☐ Yes	☐ No
AIDS/HIV-positive	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No
Autoimmune disease	☐ Yes	☐ No

Other: _____

Hematology

Hemophilia (bleeding disorder)	☐ Yes	☐ No
Blood transfusion (list date)	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Other: _____

Psychiatric

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Other: _____

Tuberculosis	☐ Yes	☐ No

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Do you have or have you had any of the following?

Past illnesses

German measles ☐ Yes ☐ No
Mumps ☐ Yes ☐ No
Syphilis/gonorrhea ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No

Cancer ☐ Yes ☐ No
If so, what type: _____

Family history of the patient

Father: ☐ Living ☐ Deceased Age: _____ Cause of death: _____

Mother: ☐ Living ☐ Deceased Age: _____ Cause of death: _____

Brother: ☐ Living ☐ Deceased Age: _____ Cause of death: _____

Brother: ☐ Living ☐ Deceased Age: _____ Cause of death: _____

Sister: ☐ Living ☐ Deceased Age: _____ Cause of death: _____

Sister: ☐ Living ☐ Deceased Age: _____ Cause of death: _____

Has any immediate family member had any of the following?

Cancer ☐ Yes ☐ No
What type: _____
High blood pressure ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Early hearing loss ☐ Yes ☐ No

Thyroid/parathyroid issues ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Heart trouble ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Problems with anesthesia ☐ Yes ☐ No

Please give any other information that may be helpful in your treatment: _____

_____

_____

_____

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.

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