

ENT Clinic of Iowa, P.C.  
1455 29<sup>th</sup> Street  
Des Moines, IA 50266

ENT Clinic of Iowa, P.C.  
601 E. Locust St., Suite 201  
Des Moines, IA 50309

Today's Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Physician or Family Physician: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

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 _____	
<b>Psychiatric:</b>			
Mental illness	yes/no	Other _____	
Anxiety	yes/no	_____	
Depression	yes/no	_____	
<b>Past Illness:</b>			
German Measles	yes/no	Hepatitis	yes/no
Mumps	yes/no	AIDS	yes/no
Syphilis / Gonorrhoea	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.**

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**\*\*\*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.**

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**FOR OFFICE USE ONLY**

**Physician's initials after review**

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