

# Iowa ENT & Sinus Surgery Center, P.C.

## F.E. Gonzales, MD FACS

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

Date of Last Physical Exam: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: (currently taking) \_\_\_\_\_

Surgeries: \_\_\_\_\_ Hospitalizations: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Resp: \_\_\_\_\_ BP: \_\_\_\_\_

**PLEASE MARK "YES" OR "NO" TO ALL OF THE FOLLOWING QUESTIONS. IT IS IMPORTANT HEALTH HISTORY INFORMATION**

Does your child currently have or have you had in the past year?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any weight change, fever, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throats
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	History of strep throat
<input type="checkbox"/>	<input type="checkbox"/>	Enlargement / inflammation of lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing, shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light, double vision	<input type="checkbox"/>	<input type="checkbox"/>	Delayed speech
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Periods where you stop breathing while sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Failed hearing test	<input type="checkbox"/>	<input type="checkbox"/>	Neck swelling, goiter
<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from ears	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hayfever
		How often _____			To what _____
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears, or fullness in ears			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic nasal congestion			
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Trauma to nose	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain, c/o N&V
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Increase in nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Depression or mood swings
			<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Past Illness:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia / bleeding disorder
<input type="checkbox"/>	<input type="checkbox"/>	AIDS (HIV positive)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Family History of the patient:

	Age	If living, health	If deceased (age at death / cause)
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____

Has any relative ever had the following:

		(relative - mother / father / grandparents / brothers / sisters)						
Yes	No	Yes	No	Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	Diabetes	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	Heart trouble	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	Hemophilia	Other: _____

Completed By: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_