ALLERGY & ENT ASSOCIATES

PATIENT NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

REFERRED BY _____ ACCOMPANIED TODAY BY _____

LIST FAMILY MEMBERS WHO ARE ALSO PATIENTS OF ALLERGY & ENT ASSOCIATES _____

ALLERGY HISTORY			
DO YOU HAVE ALLERGIES/HAY FEVER?	☐ YES ☐ NO		IF YES, AGE BEGAN _____
FOOD ALLERGY/INTOLERANCE:	LIST ALL FOODS BELOW:	AGE ONSET:	REACTION:
CONTACT ALLERGIES:	LIST CONTACT ALLERGENS BELOW:	AGE ONSET:	REACTION:
INSECT REACTIONS:	LIST INSECTS BELOW:	AGE ONSET:	REACTION:
HAVE YOU EVER BEEN TESTED FOR ALLERGIES?	☐ YES ☐ NO		
HOW WAS TESTING PERFORMED?	☐ SKIN (PRICKS) ☐ BLOOD (RAST)		
HOW LONG AGO WAS THE TEST?			
WHAT WERE YOU TOLD YOU WERE ALLERGIC TO?			
DID YOU RECEIVE IMMUNOTHERAPY?	☐ NO ☐ YES, SHOTS ☐ YES, DROPS		
HAVE YOU EVER BEEN PRESCRIBED AN EPIPEN (ADENALINE/EPINEPHRINE)?	☐ YES ☐ NO		

SINUS HISTORY	
DO YOU HAVE SINUS PROBLEMS?	☐ YES ☐ NO
WHICH ANTIBIOTICS HAVE YOU BEEN ON IN THE LAST YEAR?	
NUMBER OF TIMES TREATED FOR SINUS INFECTION WITH AN ANTIBIOTIC IN THE PAST YEAR:	_____
HAVE YOU EVER HAD AN X-RAY OR CT SCAN OF YOUR SINUSES?	☐ YES ☐ NO
IF YES, WHERE WAS THE X-RAY/CT SCAN PERFORMED?	
IF YES, WHEN WAS THE X-RAY/CT SCAN PERFORMED?	

ALLERGY & ENT ASSOCIATES

RESPIRATORY HISTORY	YES	NO
BREATHING/ASTHMA SYMPTOMS, INCLUDING COUGHING, WHEEZING, OR SHORTNESS OF BREATH?	☐	☐
RECURRENT BRONCHITIS, CROUP, ASTHMA, REACTIVE AIRWAY DISEASE DURING CHILDHOOD?	☐	☐
HAVE/HAD COLDS THAT GO "TO THE CHEST" AND TAKE MORE THAN 10 DAYS TO GET OVER?	☐	☐
NUMBER OF SYMPTOM-FREE DAYS IN THE LAST 2 WEEKS?	_____	
NUMBER OF EMERGENCY VISITS FOR BREATHING SYMPTOMS IN THE LAST 6 MONTHS?	_____	
NUMBER OF EXACERBATIONS REQUIRING ORAL SYSTEMIC CORTICOSTERIODS IN THE LAST 12 MONTHS?	_____	
WHAT AGE DID YOUR BREATHING SYMPTOMS BEGIN?	_____	
HOW OFTEN DO YOU USE BETA AGONIST INHALER (PROVENTIL, ALBUTEROL, VENTOLIN) PER DAY?	_____	

FREQUENCY OF BREATHING SIGNS/SYMPTOMS OVER THE PAST 2-4 WEEKS (NOT JUST ACUTE ATTACKS:

SYMPTOM TYPE	NUMBER	FREQUENCY
NUMBER OF DAYTIME SYMPTOMS:		
NUMBER OF NIGHTTIME SYMPTOMS:		
NUMBER OF ACUTE ATTACKS/EXACERBATIONS:		

HEARING HISTORY	
DO YOU FEEL THAT YOU/YOUR CHILD'S HEARING IS CHANGING?	☐ YES ☐ NO ☐ UNSURE
HAVE YOU/YOUR CHILD EVER BEEN EXPOSED TO LOUD NOISES EITHER RECENTLY OR IN THE PAST YEAR?	☐ YES ☐ NO ☐ UNSURE
HAVE YOU/YOUR CHILD HAD EAR INFECTIONS?	☐ YES ☐ NO ☐ UNSURE
ARE YOU/YOUR CHILD CURRENTLY IN OR PAST USED A HEARING DEVICE?	☐ YES ☐ NO ☐ UNSURE
FOR UNDER 15 YEARS OF AGE ONLY:	
DID THEY PASS THEIR NEWBORN HEARING SCREEN?	☐ YES ☐ NO
IF NO, PLEASE CHECK ALL THAT APPLY:	
WAS THERE AN ABNORMAL PREGNANCY/DELIVERY?	☐ YES ☐ NO
HISTORY OF DRUG USE OR STD DURING PREGNANCY?	☐ YES ☐ NO
HAS THERE BEEN ANY SPEECH DELAY?	☐ YES ☐ NO
CHILD CURRENTLY RECEIVING SPEECH THERAPY?	☐ YES ☐ NO
OTHER COMMENTS:	

ALLERGY & ENT ASSOCIATES

YOUR MEDICAL HISTORY (PROVIDE DATE OF ONSET)								
CONDITION		ONSET	CONDITION		ONSET	CONDITION		ONSET
☐	ACID REFLUX		☐	DEVIATED NASAL SEPTUM		☐	OSTEOPOROSIS	
☐	ALLERGIC RHINITIS		☐	DIABETES		☐	PEPTIC ULCER DISEASE	
☐	ALLERGIES		☐	EAR INFECTIONS, ACUTE		☐	PLEURISY	
☐	ANEMIA		☐	EAR INFECTIONS, CHRONIC		☐	PNEUMONIA	
☐	ANXIETY		☐	ECZEMA		☐	RENAL DISEASE	
☐	ARTHRITIS		☐	HIGH CHOLESTEROL		☐	SEIZURE DISORDER	
☐	ASTHMA		☐	GALLBLADDER DISEASE		☐	SINUSITIS	
☐	ATOPIC DERMATITIS		☐	GERD		☐	SLEEP APNEA	
☐	BRONCHITIS		☐	HEADACHE, MIGRAINE		☐	STROKE	
☐	CANCER		☐	HEADACHES		☐	THYROID DISEASE	
☐	CONTACT DERMATITIS		☐	HEPATITIS/LIVER DISEASE		☐	TONSILLITIS	
☐	COPD		☐	HYPERTENSION		☐	TUBERCULOSIS	
☐	CORONARY ARTERY DISEASE		☐	HEART ATTACK		☐	URTICARIA (RASH/HIVES)	
☐	DEPRESSION		☐	NASAL FRACTURE				
☐	OTHER MEDICAL HISTORY:							

YOUR SURGICAL HISTORY (PROVIDE DATE OF SURGERY)								
PROCEDURE		DATE	PROCEDURE		DATE	PROCEDURE		DATE
☐	ADENOIDECTOMY		☐	HEART BYPASS		☐	KNEE SURGERY	
☐	ANGIOPLASTY		☐	CHOLECYSTECTOMY		☐	EAR TUBES	
☐	APPENDECTOMY		☐	GASTRIC BYPASS		☐	THYROIDECTOMY	
☐	BACK SURGERY		☐	HERNIA REPAIR		☐	TONSILLECTOMY	
☐	BLOOD TRANSFUSION		☐	HIP REPLACEMENT				
☐	OTHER SURGICAL HISTORY:							

ALLERGY & ENT ASSOCIATES

FAMILY MEDICAL HISTORY		
☐ NO KNOWN FAMILY HISTORY		
I HAVE A FAMILY HISTORY OF:		CHECK ALL THAT APPLY
☐	ALLERGIES	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	ALLERGIES, ENVIRONMENTAL	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	ALLERGIES, FOOD	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	ASTHMA	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	AUTOIMMUNE DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	BLOOD DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	CANCER	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
		TYPE: _____
☐	CORONARY ARTERY DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	CARDIOVASCULAR DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	CYSTIC FIBROSIS	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	DEPRESSION	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	DIABETES	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	ECZEMA	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	ELEVATED LIPIDS	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	EMPHYSEMA	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	GENETIC DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	HAY FEVER	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	HEREDITY ANGIODEMA	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	HIVES	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	HYPERTENSION	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	PERIPHERAL VASCULAR DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	RENAL (KIDNEY) DISEASE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	SEIZURE DISORDER	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	SINUSITIS	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	STROKE	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	SYSTEMIC LUPUS ERTHEMATOSIS	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	THYROID DISORDER	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	TUBERCULOSIS	☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER
☐	OTHER:	

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SOCIAL HISTORY			
SMOKING TOBACCO USE:	☐ NEVER SMOKER ☐ CURRENTLY SMOKE ☐ QUIT		
NON-SMOKING TOBACCO USE:	☐ NEVER USED ☐ CURRENTLY USE ☐ QUIT		
DO YOU DRINK ALCOHOL?	☐ YES ☐ NO ☐ FORMERLY		
OCCUPATION:		STATUS:	☐ EMPLOYED ☐ UNEMPLOYED ☐ LAID OFF ☐ QUIT

RESIDENCE			
TYPE OF RESIDENCE:		DUST MITE COVER ON PILLOW?	☐ YES ☐ NO
AGE OF BUILDING:		DUST MITE COVER ON MATTRESS?	☐ YES ☐ NO
TIME AT CURRENT ADDRESS:		TYPE OF BED:	
CENTRAL HEATING/AC:		DOWN BEDDING:	☐ YES ☐ NO
TYPE OF HEAT:		DAMP/MOLDY AREAS OF HOUSE:	☐ YES ☐ NO
SMOKER IN HOME:	☐ YES ☐ NO	TYPE OF FLOORS:	
RELATIONSHIP TO SMOKER:		VACUUM FREQUENCY:	
ANIMALS AT HOME:	☐ YES ☐ NO	NUMBER OF ANIMALS:	
ALLERGY SYMPTOMS INCREASE AT WORK?		☐ YES ☐ NO	
YARD:			
BEDROOM CONTENTS:			

ANIMALS/ENVIRONMENTAL				
NUMBER	ANIMAL TYPE	LENGTH OF OWNERSHIP	KEPT INSIDE	KEPT IN BEDROOM
			☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO

HOBBIES

CHEMICALS AT HOME

CHEMICALS AT WORK

ALLERGY & ENT ASSOCIATES

PLEASE MARK ALL SYMPTOMS YOU ARE CURRENTLY OR HAVE RECENTLY EXPERIENCED:							
HEENT		**RESPIRATORY**		**GI**		**EMOTIONAL**	
☐	BAD BREATH	☐	COUGH	☐	ABDOMINAL PAIN	☐	ANXIETY
☐	BURNING EYES	☐	CHEST CONGESTION	☐	BELCHING	☐	DEPRESSION
☐	EAR POPPING	☐	FREQUENT UPPER RESP. INFECTIONS	☐	CHANGE IN APPETITE	☐	OTHER:
☐	EYE REDNESS	☐	PAIN BREATHING	☐	CONSTIPATION	**METABOLIC/ ENDOCRINE**	
☐	EYE ITCHING	☐	SHORTNESS OF BREATH	☐	DIARRHEA	☐	ABNORMAL SLEEP PATTERN
☐	EYE TEARING	☐	SHORTNESS OF BREATH AT NIGHT	☐	FLATULENCE (GAS)	☐	SLEEP/AWAKE PATTERN CHANGE
☐	EYE DISCHARGE	☐	SHORTNESS OF BREATH W/ EXERCISE	☐	HEARTBURN	☐	DECREASED ACTIVITY
☐	EAR DRAINAGE	☐	WHEEZING	☐	LOSS OF APPETITE	☐	OTHER:
☐	EAR PAIN	☐	OTHER:	☐	NAUSEA	**MUSCULOSKELETAL**	
☐	EAR INFECTIONS	**SKIN**		☐	REFLUX	☐	JOINT PAIN
☐	NOSEBLEEDS	☐	DRY SKIN	☐	VOMITING	☐	JOINT SWELLING
☐	FACIAL PAIN	☐	ECZEMA	☐	OTHER	☐	OTHER:
☐	FREQUENT SORE THROAT	☐	HAIR LOSS	**CARDIAC**		**HEMATOLOGIC/ LYMPHATIC**	
☐	FREQUENT THROAT CLEARING	☐	HIVES	☐	CHEST PAIN	☐	LYMPHADENOPATHY
☐	HEARING LOSS	☐	PRUITUS (ITCHING)	☐	CHEST TIGHTNESS	☐	OTHER:
☐	HOARSENESS	☐	RASH	☐	HEART PALPITATIONS	**NEURO**	
☐	IMPAIRED SMELL	☐	SKIN LESION	☐	OTHER:	☐	ABNORMAL SLEEP PATTERN
☐	ITCHY THROAT	☐	SKIN SWELLING	**GENERAL**		☐	DIZZINESS
☐	NASAL CONGESTION	☐	OTHER:	☐	CHILLS	☐	FAINTING
☐	NASAL DRAINAGE	**ALLERGY**		☐	FATIGUE	☐	HEADACHE
☐	POST NASAL DRAINAGE	☐	CONTACT ALLERGY	☐	FEVER	☐	SEIZURES
☐	SINUS PRESSURE	☐	ENVIRONMENTAL ALLERGY	☐	INSOMNIA	☐	OTHER:
☐	SNORING	☐	FOOD ALLERGIES	☐	MALAISE	**LIST ANY OTHER SYMPTOMS:**	
☐	SWOLLEN/PUFFY EYES	☐	SEASONAL ALLERGIES	☐	NIGHT SWEATS		
☐	TOOTH PAIN	☐	BEE STING ALLERGIES	☐	WEIGHT GAIN		
☐	TROUBLE SWALLOWING		OTHER:		WEIGHT LOSS		
☐	VERTIGO/DIZZY				OTHER:		

ALLERGY & ENT ASSOCIATES™

MEDICATION – ALLERGIES	
DO YOU HAVE ANY KNOWN DRUG ALLERGIES OR INTOLERANCE(S) TO MEDICATIONS?	☐ YES ☐ NO

PLEASE LIST ALL KNOWN DRUG ALLERGIES OR INTOLERANCE(S) BELOW:

MEDICATION	TYPE OF REACTION	DATE

MEDICATION – HISTORY

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER, HERBALS, CREAMS, SPRAYS, ETC.

MEDICATION	DOSE	FREQUENCY	TAKEN FOR:

PHARMACY INFORMATION

PHARMACY NAME:	
PHARMACY ADDRESS:	
PHARMACY PHONE NUMBER:	
PRESCRIPTION TYPE:	☐ 90-DAY MAIL-IN ☐ LOCAL ☐ MAIL-IN AND LOCAL