Allergy & ENT Associates - ENT Established Patient Questionnaire

Patient Name	Date of Birth	Today's date

Reason for Visit:

□ Sinus problems	□ Pre/Post Op Appointment	□ Cosmetic
□ Ear problems	□ Nose bleeds	□ Other____________

Since your last visit

Have you been satisfied with your health? □ Yes □ No

Have your medications caused any problems? □ Yes □ No

If yes, what problems did they cause? (Mark all that apply)

□ sleeplessness	□ drowsiness	□ nervousness	□ headache
□ shakiness	□ sore throat	□ cough	
□ other ______________________			

Has your family or medical history changed? □ Yes □ No

If yes, list any changes: ______________________

Has your social history changed? (occupation, alcohol, drug use etc.) □ Yes □ No

If yes, list any changes:

Have you ever used tobacco? □ Yes □ No □ Unknown

Passive/Second hand smoke exposure? □ Yes □ No Who/Where: ______________

Have there been any significant changes in your home or work environment? □ Yes □ No

If yes, list any changes: ______________________

Have you had breathing problems or asthma symptoms including coughing, wheezing, or shortness of breath over the past 2-4 weeks (not just with acute attacks)? □ Yes □ No

# of Daytime Symptoms:	__________	Frequency	□ Daily	□ Weekly	□ Monthly
# of Daytime Symptoms:	__________	Frequency	□ Daily	□ Weekly	□ Monthly

Have you had any emergency room visits or hospital stays? □ Yes □ No

Do you have any problems you wish to discuss? □ Yes □ No

If yes, please list the problems to discuss:	

ENT Established Patient Questionnaire - Page 2

Patient Name **Date of Birth**

Current Medications		
Please list your prescription, non - prescription, herbal drugs, creams, sprays, pills, liquids, or drops.		
Medication Name	**Dose**	**Frequency**

Medication Allergies		
Do you have any drug allergies or intolerance to medications?		□ Yes □ No
Medication Name	**Type of Reaction**	**When/Date**

Nasal Rinse

Are you using a nasal saline rinse ? □ **Yes** □ **No**

If yes, how many times a day? ____________

Is this a medicated sinus rinse? □ **Yes** □ **No**

Other Notes:

Current Pharmacy Information

Pharmacy Name: ____________

Pharmacy Address: ____________

Street

City **State** **Zip**

Pharmacy Phone #: ____________

Pharmacy Fax #: ____________

Prescription Type: □ **90 day mail in** □ **Local** □ **Mail & Local**