ENT & ALLERGY ASSOCIATES, S.C.

New Patient History

Name: _____DOB: _____Age:_____Date:_____

Referring provider: _____

Family Doctor: _____

What are you being seen for today? *(When did symptoms start? How frequent? What makes them worse or better?)*

_____
_____
_____
_____

On a scale of 1 to 10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability? **Worst 1 2 3 4 5 6 7 8 9 10 Best**

Current Medications *(Please list current medications or provide a list for us to copy)*

____ **No Medications**	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies

Drug	**Reaction**	**Date** *(approximate)*
____ **No Known Drug Allergies**	_____	_____
_____	_____	_____
_____	_____	_____

Family History *(Please indicate (F)ather, (M)other, (B)rother, (S)ister)*

- ☐ Adopted –limited-history
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bleeding disorder
- ☐ Cystic fibrosis
- ☐ Genetic mutations or syndromes
- ☐ Hayfever/allergies
- ☐ Hearing loss
- ☐ Immune deficiency
- ☐ Malignant hyperthermia (high fever during general anesthesia)
- ☐ Thyroid disorder
- ☐ Diabetes (type)___
- ☐ NONE

Past Medical History *(Please check significant medical problems for which you have seen a doctor in the past)*

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (type) _____
- ☐ Asthma
- ☐ Auto Immune Disorder (type) _____
- ☐ Bleeding disorder
- ☐ Blindness
- ☐ Blood thinner use
- ☐ Bronchitis
- ☐ Cancer (type) _____
- ☐ Cataracts
- ☐ Currently pregnant
- ☐ Depression
- ☐ Diabetes (type)___
- ☐ Ear infections
- ☐ Eczema
- ☐ Emphysema/copd
- ☐ GERD/reflux
- ☐ Glaucoma
- ☐ Hayfever/allergies
- ☐ Hearing loss
- ☐ Heart Attack/MI
- ☐ Hepatitis A/B/C
- ☐ High blood pressure
- ☐ Hospitalizations due to asthma
- ☐ Hyperlipidemia
- ☐ Irregular heartbeat
- ☐ Kidney problems
- ☐ Latex allergy
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Nasal obstruction
- ☐ Nosebleeds
- ☐ Obstructive sleep apnea
- ☐ Other_____ _____
- ☐ Pacemaker or defibrillator
- ☐ Parkinsonism
- ☐ Pneumonia
- ☐ RSV
- ☐ Sarcoidosis
- ☐ Seizure disorder
- ☐ Sinusitis
- ☐ Snoring
- ☐ Stroke/TIA
- ☐ Thyroid disorder
- ☐ Thyroid nodules
- ☐ Tinnitus (ears ringing)
- ☐ Tonsil problems/tonsillitis
- ☐ Trouble swallowing or dysphagia
- ☐ Tuberculosis
- ☐ Vertigo (room spinning)
- ☐ Voice problems or hoarseness
- ☐ NONE

Please continue to next page.

Past Surgical History *(Please check surgeries you have had in the past)*

- ☐ Adenoidectomy and Tonsillectomy (date) _____
- ☐ Adenoidectomy (date) _____
- ☐ Anesthesia problems (List)
- ☐ Appendectomy
- ☐ Bariatric surgery (obesity)
- ☐ Bladder repair
- ☐ Bone fractures
- ☐ Bowel resection
- ☐ Breast biopsy (benign)
- ☐ C-section
- ☐ Carotid cleanout
- ☐ Cataracts
- ☐ Ear reconstruction (date) _____
- ☐ Ear tubes (date) _____
- ☐ Gall bladder or cholecystectomy
- ☐ Gastric reflux (Nissen)
- ☐ Glaucoma
- ☐ Head and neck skin cancer (date) _____
- ☐ Heart bypass (CAGB)
- ☐ Heart valve repair
- ☐ Hemorrhoid
- ☐ Hernia
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Kidney stone
- ☐ Kidney transplant
- ☐ Knee replacement
- ☐ Knee scope
- ☐ Lung removal partial/whole
- ☐ Lung transplant
- ☐ Mastectomy
- ☐ Nasal surgery (date) _____
- ☐ Other_____ _____
- ☐ Ovary removed
- ☐ Retinal repair
- ☐ Salivary gland (date) _____
- ☐ Sinus surgery (date) _____
- ☐ Spine surgery
- ☐ Thyroidectomy (date) _____
- ☐ Tonsillectomy (date) _____
- ☐ Tubal ligation
- ☐ NONE

Social History *(check all that apply)*

- ☐ Alcohol use
  - Drinks per week: _____
- ☐ Chewing tobacco
  - Cans per week: _____
  - Date started: _____
  - Date stopped: _____
- ☐ History of illicit or street drug use (in past 10 years) Types: _____
- ☐ History of IV drug use
- ☐ **Never Smoked**
- ☐ Smoking history
  - Packs per day: _____
  - Date started: _____
  - Date stopped: _____

If you are seeing Allergy today complete this section:

Environmental History *(Check all that apply)*

- ☐ Carpeting
- ☐ Central heat/air conditioning
- ☐ Daycare
- ☐ Feather pillow
- ☐ Housing owned, Age of home: ___
- ☐ Housing rental, Age of home: ___
- ☐ Indoor pets (list pets)
- ☐ In-home air filter
- ☐ Inner spring mattress
- ☐ Never smoker
- ☐ Occupation: _____
- ☐ Second hand smoke (list source)
- ☐ Upholstered bedroom furniture
- ☐ Wet/damp basement