Southwest Ohio ENT Specialists, Inc, Allergy Department

Date_____

Name_____ DOB_____

Address _____City/State_____

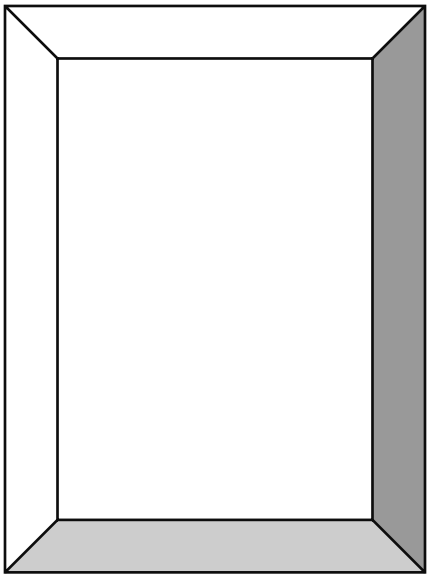
Zip Code _____ Phone # _____ Work # _____

Employer _____ Occupation _____

ER Contact/Relationship_____ Phone # _____

Insurance Provider_____ Policy # _____

Medication Allergies_____



Do you take medication for the following?

High Blood Pressure? ☐ Yes ☐ No
Name of Medication _____

Glaucoma? ☐ Yes ☐ No
Name of Medication _____

Migraines? ☐ Yes ☐ No
Name of Medication _____

Arrythmia? ☐ Yes ☐ No
Name of Medication _____

Current Medications

_____

_____

_____

_____

Please check any that apply;
☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Breast Cancer
☐ Thyroid Disease ☐ Asthma ☐ Wheezing ☐ Hepatitis ☐ HIV ☐ Aids
☐ Nasal Surgery ☐ Sinus Surgery

Have you ever been tested for allergies? ☐ Yes ☐ No

Have you ever received treatment for your allergies? ☐ Yes ☐ No

Tell us about your symptoms

Check any of the following that are a problem for you:

☐ runny nose ☐ watery eyes ☐ itchy ears ☐ head aches
☐ stuffy nose ☐ red eyes ☐ ear pain or popping
☐ itchy nose ☐ itchy eyes ☐ itchy throat
☐ sneezing ☐ postnasal drip ☐ throat clearing ☐ coughing

SINUS INFECTIONS, EAR INFECTIONS

Do you have frequent ear infections? ☐ Yes ☐ No
Do you have frequent sinus infections? ☐ Yes ☐ No
If yes, how many in the last year? Ear_____ Sinus_____

Which of the following medications have you used for your symptoms?

☐ oral antihistamines (e.g. loratadine, Claritin, cetirizine, Zyrtec, fexofenadine, Allegra, diphenhydramine, Benadryl
☐ oral decongestants (e.g. pseudoephedrine, Sudafed)
☐ nasal steroids (e.g. fluticasone, Flonase, mometasone, Nasonex, mometasone furoate, triamcinolone, Nasocort
☐ antihistamine nose spray (e.g. Patanase, Astelin, Astepro)
☐ combination antihistamine/steroid nose spray (Dymista)
☐ nasal spray decongestant (e.g. oxymetazoline, Afrin, neosynephrine)
☐ nasal saline

Do you have pets?

☐ Dogs How many_____ ☐ Inside ☐ Outside
☐ Cats How many _____ ☐Inside ☐ Outside
☐ Hamsters ☐ Guinea Pigs ☐ Birds ☐ Other

Are your symptoms year-round ☐ or seasonal ☐ What is your worst season? _____
Do you or any members of your household smoke? ☐ Yes ☐ No
How old is your home? _____ years. Do you live on a farm? ☐ Yes ☐ No
Do you use wood to heat your home? ☐ Yes ☐ No
Do you have a basement? ☐ Yes ☐ No Is it damp? ☐ Yes ☐ No
Have you ever fainted or passed out? ☐ Yes ☐ No
Do you suffer from depression? ☐ Yes ☐ No
Do you have chronic anxiety? ☐ Yes ☐ No
Females: Are you pregnant or breastfeeding? ☐ Yes ☐ No

Please tell us anything that you feel we may need to know about your symptoms.

_____
_____
_____
_____
_____