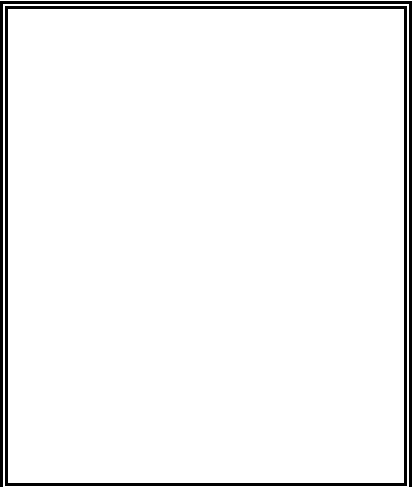


# Southwest Ohio ENT Specialists Allergy Department

Date \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_  
 SS# \_\_\_\_\_ Ins. Co \_\_\_\_\_ Policy # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Are You? \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Student \_\_\_\_\_  
 Emergency Contact/Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
  
 Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
 Medication Allergies \_\_\_\_\_  
 Current Medications \_\_\_\_\_

**MEDICAL HISTORY - CHECK ALL THAT APPLY \*\*\* (HX = HISTORY OF) \*\*\***

\_\_\_\_\_ High Blood Pressure \_\_\_\_\_ HIV  
 \_\_\_\_\_ Asthma/Lung difficulties \_\_\_\_\_ AIDS  
 \_\_\_\_\_ HX. Wheezing \_\_\_\_\_ Diabetes (Circle One) Oral Med Insulin  
 \_\_\_\_\_ Heart Disease \_\_\_\_\_ Cancer (Circle One) Chemo Radiation  
 \_\_\_\_\_ Depression \_\_\_\_\_ Hepatitis (Circle Type) A B C  
 \_\_\_\_\_ Thyroid Disorder \_\_\_\_\_ Auto Immune Disorder



**Primary Allergy Symptoms** (Circle all that apply) Cough Sore throat Sneezing  
 Congestion Runny nose PND Ear: pain - popping - sounds  
 Eyes: itch - water - red Decreased: smell - taste GI: bloating - reflux  
 Other: \_\_\_\_\_

**Previous Testing** \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_ Injections \_\_\_\_\_  
**Sinus/Nasal Surgeries** \_\_\_\_\_ Yes \_\_\_\_\_ No  
**Symptoms** \_\_\_\_\_ All year \_\_\_\_\_ Seasonal **Worst Season** \_\_\_\_\_  
**Do you live in a :** \_\_\_\_\_ House \_\_\_\_\_ Apt. \_\_\_\_\_ Farm \_\_\_\_\_ **House age** \_\_\_\_\_  
**Basement** \_\_\_\_\_ Yes \_\_\_\_\_ No **A/C** \_\_\_\_\_ Yes \_\_\_\_\_ No  
**Pets** \_\_\_\_\_ # Dogs \_\_\_\_\_ # Cats \_\_\_\_\_ Other \_\_\_\_\_ **Inside** \_\_\_\_\_ **Outside** \_\_\_\_\_  
**Hobbies** \_\_\_\_\_ **HX:** \_\_\_\_\_ **Chemical Exposure** \_\_\_\_\_ **Food Allergies** \_\_\_\_\_  
**Pillow Type** \_\_\_\_\_ Polyester \_\_\_\_\_ Feather \_\_\_\_\_ Foam \_\_\_\_\_ Other \_\_\_\_\_  
**Type of heat** \_\_\_\_\_ Electric \_\_\_\_\_ Gas \_\_\_\_\_ Oil \_\_\_\_\_ Wood \_\_\_\_\_  
**Alcohol** \_\_\_\_\_ Yes \_\_\_\_\_ No **Quantity** \_\_\_\_\_ Week \_\_\_\_\_ **Total Year** \_\_\_\_\_  
**Tobacco** \_\_\_\_\_ Yes \_\_\_\_\_ No **Quantity** \_\_\_\_\_ Week \_\_\_\_\_ **Total Year** \_\_\_\_\_  
**Exposure from Others** \_\_\_\_\_ Yes \_\_\_\_\_ No

**Females Only** \_\_\_\_\_ **Pregnant** \_\_\_\_\_ **Nursing** \_\_\_\_\_