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**