Ear Nose & Throat Care P.C. & Allergy Allergy/Health History

Patient Name_____ Today's Date_____

Review of Systems – Circle if patient has had any of these symptoms NOW OR RECENTLY

Constitution	Alopecia/ hair loss	**Endocrine**	**Allergy**
Decreased appetite	Contact dermatitis	Cold intolerance	Drug (specify)
Chills	Eczema	Heat intolerance	Food (specify)
Failure to thrive	Hives/swelling	Other_____	Latex
Fatigue	Rashes	**ENT**	Metal (jewelry)
Fever	Itching	Bad breath/taste	Seasonal
Night sweats	Other_____	Difficulty smelling	Surgical tape
Weight change	**Eyes/Head**	Ear discharge	Other_____
Other_____	Itchy eyes	Ear itching	**Musculoskeletal**
Lungs	Migraine headaches	Ear pain	Back pain
Chest tightness	Pressure/congestion	Hearing loss	Joint pain
Chronic cough	Redness of eyes	Post nasal drip	Muscle pain
Difficulty exercising	Sinus headaches	Sneezing	Muscle weakness
Short of breath	Tension headaches	Snoring	Osteoporosis
Sputum	Swollen eyes	Sore throat	Stiffness
Wheezing	Watery eyes	Tinnitus (ear ringing)	Other_____
Other_____	Other_____	Throat clearing	**Psychiatry**
Hematology	**Cardiovascular**	Other_____	Anxiety
Anemia	Edema/swelling	**GI**	Depression
Bleeding	Fainting	Abdominal pain	Developmental delay
Bruise easily	Murmurs	Constipation	Hyperactive
Swollen glands	Palpitations	Diarrhea	Irritable
Other_____	Other_____	Heartburn (reflux)	Mood swings
Skin	**GU**	Nausea	Stress
Acne	Difficulty urinating	Vomiting	Other_____
Family History of Allergies – circle: None Parents Brother or Sister			

Height _____ Weight _____

Social and environmental history – Circle all those that apply to the patient

Pet exposures- circle and put number if more than one

None	Dog	Cat	Bird	Rodent_____	Other_____

When? Past/Current How long in family?_____yrs.

Housing

House	Apartment	Condo	Farm

How long have you lived at this residence?_____yrs. How old is your residence?_____yrs

Do you live in:

Suburbs	Rural/countryside	City

PLEASE CONTINUE ON OTHER SIDE

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Patient Name_____ Today's Date_____

Bedding

Pillow	Synthetic	Feather	Unknown material	Down comforter?
Mattress	Synthetic	Feather	Unknown material	Allergen-proof covers?

Floor covering – circle as appropriate for patient

Bedroom	Rugs	Wall-to-wall carpet	Tile	Wood
Rest of house	Rugs	Wall-to-wall carpet	Tile	Wood

HVAC

Air conditioning	Central	Wall	None	Humidifier	
Heating	Forced air	Radiant	Stove	Unknown	

Basement: None Unfinished Finished Is there chronic leakage?_____

Patient smokes Y/N Packs/day_____ for____ years Quit Y/N Exposed to secondhand smoke Y/N

Occupation_____ Work mainly Inside Outside

Exposure to: Chemicals Dusty materials Building materials Irritants_____

Allergens Young children No irritants/allergens Feel worse at work than home?

Social

Alcohol use	None	Social	Moderate	Drinks/wk?_____
Caffeine	None	Occasional	Large	Avoids
	Coffee	Tea	Caffeinated soft drinks	

Birth History – Complete for children under age 18

Birth weight_____lb_____oz Vaginal delivery Y/N C/Section Y/N Premature Y/N Weeks_____

Complications_____

Feeding Formula only Y/N Breast fed Y/N How long?_____

Transitioned from breast milk without problems Y/N

Problems transitioning from breast milk?_____

Are immunizations up to date?_____

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