Ear Nose and Throat P.C. & allergy Allergy/Health History

Patient name: _____ Today's Date:_____

Allergy/Health Questions 2– Social and environmental history – Circle all those that apply to the patient

Family History of Allergies: None Parents Brother/Sister

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

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	Radiator	Stove	Unknown	

Basement

None Unfinished Finished Is there a chronic leakage?_____

Smoke Exposure

Patient smokes Y/N packs/day_____ for _____years Quit exposed to secondhand smoke Y/N

Employment

Occupation: _____ Work mainly: Inside Outside
Exposed to: Chemicals Dusty materials Building materials Irritants Allergens Young children no irritants/allergens Feels worse at work than home?

Social

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

Please continue on other side

Allergy/Health Questions 1– Circle if patient has had any of these symptoms <u>IN THE LAST MONTH</u>

Constitution	Alopecia/hair loss	**Endocrine**	**Allergy**
Decrease appititie	Contact dermatitis	Cold intolerance	Drug (specify):
Chills	Eczema	Heart 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 headache	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	Palptations	Diarrhea	Irritable
Other:_____	Other:_____	Heartburn (reflux)	Mood swings
Skin	**GU**	Nausea	Stress
Acne	Difficult urinating	Vomiting	Other: _____

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
Problem transitioning from breast milk? _____
Are immunizations up to date? _____

Please continue on other side