ENT & ALLERGY CENTER OF AUSTIN
2765 Bee Caves Road, Suite 205, Austin, Texas 78746
1730 E. Whitestone Blvd., Suite 100, Cedar Park, Texas 78613
4112 Links Lane, Suite 204, Round Rock, Texas 78664
(512) 328-7722 (phone)
(512) 328-7724 (fax)
www.austinentmd.com

ENT PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Full Name _____ **Male** ☐ **Female**☐ **Date of Birth** _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ **Address** _____

(Current Medications)
Are you taking ANY kind of medication now? ☐ **No** ☐ **Yes** **If yes, please list below *include dosages*.**
(This includes prescription, over-the-counter medicines including nasal sprays, or herbal medications)

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **No** ☐ **Yes** **If yes, please list**

Name of Medication	Type of Reaction

(Non-Medication Allergies) Are you allergic to Please Circle if allergic to: Eggs, Peanuts, Seafood, other _____
Iodine ☐ **No** ☐ **Yes** **Latex** ☐ **No** ☐ **Yes, Tape** ☐ **No** ☐ **Yes, Contrast Dye?** ☐ **No** ☐ **Yes**
Have you ever had an allergy test? ☐ **No** ☐ **Yes**
(Past Health History) Have you ever been *DIAGNOSED* with any of the following problems?

Cancer (bone cancer, lung cancer, unknown type of skin cancer, thyroid cancer) other _____ ☐ **No** ☐ **Yes**

Ears:
Hearing Loss ☐ **No** ☐ **Yes**
Cerumen Impaction ☐ **No** ☐ **Yes**

Nose and Sinus:
Nasal Allergies ☐ **No** ☐ **Yes**

Heart and Blood Vessels:
High / Elevated Cholesterol ☐ **No** ☐ **Yes**
High Blood pressure ☐ **No** ☐ **Yes**

Lungs and Respiratory:
Tuberculosis ☐ **No** ☐ **Yes**

Stomach and Digestive:
Duodenal ulcer ☐ **No** ☐ **Yes**
Hepatitis ☐ **No** ☐ **Yes**
Stomach ulcer ☐ **No** ☐ **Yes**

Genitourinary:
Renal failure ☐ **No** ☐ **Yes**

Are you pregnant? ☐ **No** ☐ **Yes**

Mental & Emotional:
Anxiety ☐ **No** ☐ **Yes**
Depression ☐ **No** ☐ **Yes**

Glands, Hormones, and Sugar Control:
Diabetes ☐ **No** ☐ **Yes**
Thyroid deficiency ☐ **No** ☐ **Yes**
Thyroid excess ☐ **No** ☐ **Yes**

Blood & Lymph Node problems:
Anemia ☐ **No** ☐ **Yes**

Allergies, Immune & Infectious Problems:
HIV ☐ **No** ☐ **Yes**
Infectious mononucleosis ☐ **No** ☐ **Yes**

(Surgeries and Hospitalizations)
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**
If **yes**, please list what sort of problems. _____
Have you ever had ear, nose or throat surgery? ☐ **No** ☐ **Yes**
If **yes**, list any surgeries and when they were done. _____
Have you been hospitalized for a medical problem before? ☐ **No** ☐ **Yes**
If **yes**, list hospitalizations, the reason for admission and the date. _____

(Family History)

Specific Anesthesia Problem ☐Mother ☐Father ☐Brother ☐Sister

Cancer:
Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Ears:
Hearing Loss before age20 ☐Mother ☐Father ☐Brother ☐Sister
Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Nose and Sinus:
Nasal Allergies ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels:
Heart Disease ☐Mother ☐Father ☐Brother ☐Sister
Hypertension ☐Mother ☐Father ☐Brother ☐Sister

Lungs and Respiratory:
Asthma ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:
Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood & Lymph Node problems:
Bleeding/clotting problem ☐Mother ☐Father ☐Brother ☐Sister
Other_____ ☐Mother ☐Father ☐Brother ☐Sister

(Social History)

What is or was your occupation? _____ ☐ Check here if you are retired.

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Do you consume alcohol? ☐ **No** ☐ **Yes**
If yes, please complete the following:

Type of Alcohol	How Much	How often

Do you use drugs recreationally? ☐ **No** ☐ **Yes** **If yes, please list**_____
Are you exposed to second hand smoke? ☐ **No** ☐ **Yes**

(Review of Systems): Mark yes or no and CHECK any of the following you have recently had

Constitutional Symptoms ☐ **No** ☐ **Yes**
(☐Fever, ☐sleeping problems, ☐unintentional weight loss)

Eye problems ☐ **No** ☐ **Yes**
(☐Double vision, ☐itchy eyes)

Ears, Nose, Mouth and Throat problems ☐ **No** ☐ **Yes**
(☐Dizziness, ☐ear drainage, ☐hearing loss, ☐ear pain, ☐Ringing, ☐chronic congestion, ☐post-nasal drainage, ☐Hoarseness/change in voice, ☐snoring, ☐sore throat, ☐Ulcers)

Cardiovascular ☐ **No** ☐ **Yes**
(☐Blacking out or fainting, ☐Bluish discoloration of lips or fingernails, ☐chest pain, ☐irregular heartbeat, ☐leg cramps, ☐swelling of ankles)

Respiratory problems ☐ **No** ☐ **Yes**
(☐freq non-productive cough, ☐freq productive cough, ☐Shortness of breath, ☐wheezing)

Gastrointestinal problems ☐**No** ☐ **Yes**
(☐abdominal pain, ☐diarrhea, ☐heartburn, ☐nausea, ☐vomiting)

Musculoskeletal problems ☐ **No** ☐ **Yes**
(☐Neck pain)

Neurological problems ☐ **No** ☐ **Yes**
(☐Headache, ☐numbness, ☐severe face pain, ☐seizures, ☐weakness)

Problems with Endocrine ☐No ☐ Yes
(☐Appetite increased, ☐increased fatigue, ☐Feel hot when others do not, ☐feel cold all the time, ☐Neck has enlarged, ☐unwanted weight change)

Problems with Hematological/Lymphatic ☐ **No** ☐ **Yes**
(☐Bleeds excessively after injury, ☐bruises easily, ☐Neck masses or lumps)

Allergic, Infectious, Immunologic Problems ☐ **No** ☐ **Yes**
(☐Food intolerances, ☐hives**,** ☐Severe reaction to insect bites, ☐frequent sneezing)

What is the main reason you are seeing the doctor today?