



## ENT and ALLERGY SPECIALISTS

### MEDICAL HISTORY

Ear, Nose, & Throat

Sinus and allergy disorders

Sinus surgery

Sublingual immunotherapy

Sleep & snoring disorders

Radiofrequency & laser treatments

Head & neck surgery

Skin cancer

Speech & swallowing disorders

Ear disorders & surgery

Voice disorders

Balance disorders

Thyroid surgery

Pediatric ear, nose, & throat disorders

Audiology

Hearing evaluations

Hearing aids

Balance testing & treatment

Newborn hearing screening

Facial Plastic/Cosmetic

Facial plastic surgery

Non-invasive facial treatments

Botox/Restylane

Laser skin resurfacing

Hair removal

Skin care

Laser vein therapy

www.ENTandAllergySpecialists.com

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ DOB: \_\_\_\_\_

- 1) Please list ALL MEDICATIONS: (including over-the-counter) that you are currently taking and the reason you are taking them:

Drug:	Dose:	Times A Day	Reason you take it:

- 2) PAST MEDICAL HISTORY: (please check all that apply)

☐ HEART DISEASE ☐ ASTHMA ☐ DIABETES ☐ COPD ☐ HEPATITIS ☐ STROKE  
☐ BLEEDING DISORDER ☐ HIGH BLOOD PRESSURE

Please list any other conditions: \_\_\_\_\_

- 3) PAST SURGICAL HISTORY: (please list any surgeries that you have ever had)

Surgery	Year	Comments

- 4) OCCUPATIONAL HISTORY: \_\_\_\_\_

- 5) SOCIAL HISTORY: do you ever drink alcohol? Y/N ☐ occasionally ☐ weekly ☐ daily  
do you use tobacco of any kind? Y \_\_\_\_\_ N \_\_\_\_\_ what kind? \_\_\_\_\_  
how long? \_\_\_\_\_

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6) **FAMILY HISTORY:** ☐ HEART DISEASE ☐ ASTHMA ☐ DIABETES ☐ COPD ☐ HEPATITIS

☐ STROKE ☐ BLEEDING DISORDER ☐ HIGH BLOOD PRESSURE

please list any illnesses in the family: \_\_\_\_\_

Disease	Family Member	Comments

7) **ALLERGIES:**

1. **LATEX ALLERGY: YES OR NO**

2. ☐ PENICILLIN ☐ SULFA ☐ ERYTHROMYCIN ☐ CODEINE ☐ NONE

3. **Please list any other allergies:** \_\_\_\_\_

8) **PLEASE SIGN HERE:**

**The above responses are accurate to the best of my knowledge:**

\_\_\_\_\_  
(Signature if over 18)

\_\_\_\_\_  
(Date)

**If you are not the patient:**

\_\_\_\_\_  
(please print your name)

\_\_\_\_\_  
(relationship to patient)

**PLEASE DO NOT WRITE BELOW THIS LINE**

**DATE UPDATED:** \_\_\_\_\_ **REVIEWED BY:** \_\_\_\_\_

☐ BJB ☐ LVC ☐ PBS ☐ JEG ☐ SJT ☐ CFA ☐ LHB ☐ SEP ☐ LRP ☐ RRM

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