THE ENT& ALLERGY CENTERS OF TEXAS

Age:_____
Patient Name:_____Today's Date___/___/___**Who referred you?**_____
Why are you here today? _____
When did your symptoms first start? _____

Please describe in detail the nature of the problem: _____

_____

Medications

Please list ANY prescription or over-the-counter/herbal medications currently being taken : [] None

_____
_____
_____
_____

Are you **ALLERGIC** to any **medication**? [] No [] Yes If yes, please list below and type of reaction:

_____
_____

Please list any other serious allergies that you have not listed above: _____

_____

Past Medical and Surgical History

Please check any condition or illness you have had:

[] Kidney Disease	[] Asthma	[] Cancer	[] Psychiatric	[] Diabetes	[] Heart Disease	[] Tuberculosis
[] Liver Disease	[] High Blood Pressure	[] Bleeding Problems	[] Stroke/TIA	[] Seizures	[] COPD	
[] Thyroid Disorders	[] Gastric Reflux	[] Sleep Apnea				

Please name any other medical problems not listed above: _____

_____
_____

Any **surgeries**: [] No [] Yes If yes, list surgeries and dates:_____

_____

Have you ever experienced problems with anesthesia? [] No [] Yes. If yes, describe:_____

_____

Prior Hospitalizations: [] No [] Yes If yes, list reason for hospitalization and dates:

_____

Allergy History

Are you interested in getting Allergy Tested? [] No [] Yes
Do you have environmental allergies or sensitivities to pollens, dust, food, bees, etc? [] No [] Yes
If yes, indicate what you are allergic to and the type of reaction:_____
Have you ever had a skin or blood allergy test? [] No [] Yes If yes, indicate the year, test type, and results:_____
Have you ever taken allergy shots? [] No [] Yes If yes, indicate the year (s) and if they were helpful:_____

Hearing History

Do you have trouble hearing in a noisy background? [] No [] Yes
Do you find yourself asking people to repeat themselves? [] No [] Yes
Do family members or coworkers remark about your hearing? [] No [] Yes
Do you have dizziness, pain, or ringing in your ears? [] No [] Yes
Are you interested in getting a baseline hearing test today? [] No [] Yes

Please list any 1st or 2nd degree relatives with any of the following:
Serious illnesses or cancer: _____
Hearing loss or ear disease? _____
Anesthesia adverse reactions? _____
Bleeding/clotting disorder? _____
Other: _____

Social History

What is your occupation? _____
Do you or have you ever used tobacco of any form? [] No [] Yes If yes, list amount and duration: _____
_____
Do you or have you ever used alcohol in any form? [] No [] Yes If yes, list amount and duration: _____

Review of Systems

Please circle any symptoms that you are currently having

General	Fever	Tired	Sweating	Weight Change	
Eyes	Loss of vision	Blurry Vision	Tearing	Pain	Double Vision
Ears	Ringing Itching	Discharge Infection	Hearing Loss	Pain	Dizziness
Nose	Congestion Post-nasal drainage	Obstruction Sneezing	Pressure Bleeding	Pain Loss of Smell	Runny Nose
Throat	Snoring or Sleep Apnea Difficulty Swallowing	Loss of Taste Difficulty Chewing	Sores Hoarseness	Pain Tonsillitis	Growth Bad Breath
Neck	Mass or Lump			Pain	
Cardiovascular	Irregular Heart beat	Chest Pain	Palpitations		
Pulmonary	Shortness of breath	Dry Cough	Productive Cough	Wheezing	
Gastrointestinal	Heartburn	Indigestion	Nausea or Vomiting	Pain	Diarrhea/ Constipation
Musculoskeletal	Arthritis	Joint Pain	Muscle Aches		
Neurologic	Headaches	Tingling	Numbness		
Psychiatric	Depression	Memory Loss	Confusion	Anxiety	
Endocrine	Hyper-activity	Fatigue	Excessive Thirst	Heat Intolerance	Cold Intolerance
Renal	Trouble Urinating	Excessive Urination			

Please list anything else that you think is important to your visit today: _____
_____
_____
_____

I certify that the information provided on this medical history is correct and complete. Further, I understand that providing incorrect or incomplete medical information may not only jeopardize my health but also render ineffective or even harmful any treatments provided for me.

Patient or guardian signature: _____