EAR
NOSE
THROAT
ENT and Allergy Center

MEDICAL HISTORY FORM

Date: _____

Date of Birth: _____

Name: _____ Email: _____

I consent to the email delivery of all information, including protected health information under HIPAA ☐

List your allergies to medicines:

☐ No drug allergies ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Anesthetics

☐ Other _____

Race / Ethnicity

☐ White ☐ African / American ☐ Hispanic ☐ American Indian ☐ European ☐ Asian

☐ Other _____

Preferred Language ☐ English ☐ Spanish ☐ Other

Do you take any medications?

☐ Yes ☐ No If yes, please list _____

Do you have the following?

☐ Diabetes ☐ Hypertension ☐ Heart Disease

List any other medical conditions _____

Do any of the following conditions run in your family?

☐ Bleeding Tendency ☐ Allergy Tendency ☐ Diabetes ☐ Hepatitis B ☐ Hearing Loss ☐ Heart Disease

Alcohol / Tobacco Use:

☐ Alcohol _____ oz / day ☐ Smoke _____ packs / day ☐ Smokeless Tobacco

Do you have second hand smoke exposure? ☐ Yes ☐ No If yes, please check: ☐ Home ☐ Work ☐ Social

May we contact your pharmacy to get your medication history? ☐ Yes ☐ No

Preferred Pharmacy: _____

List any surgeries you have had _____ ☐ None

Do you have any of the following symptoms

Constitutional:	☐ Night Sweats	☐ Fatigue	☐ Weight Loss
Eyes:	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
Heart:	☐ Chest Pain	☐ Heart Palpitations	☐ Swelling in Legs
Lungs:	☐ Cough	☐ Spitting up Blood	☐ Shortness of Breath
GI:	☐ Nausea	☐ Acid Reflux	☐ Difficulty Swallowing Bone
Joint:	☐ Joint Pain	☐ Joint Swelling	☐ Muscle Cramps or Weakness
Hematology:	☐ Easy Bruising	☐ Blood Clots	☐ Lymph Node Enlargement
Skin:	☐ Rash	☐ Skin Cancer	
Psychiatric:	☐ Anxiety	☐ Depression	
Allergy:	☐ Sneezing	☐ Itching/Watery Eyes	

I authorize and consent to my blood being tested for communicable diseases if any person is exposed to my blood or other bodily fluids at the ENT and Allergy Center. _____ Date _____

2100 N. Green Acres Rd, Fayetteville, AR 72703 • **(479) 521-0455**
www.entnwa.com

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ANNUAL ALLERGY EVALUATION

Date _____ Name _____ Phone _____

Since starting allergy shots, how much trouble are you having with:

	None	Mild	Moderate	Severe	Office use only
Nasal congestion and fullness					Provider recommendation: Continue shots Schedule re-evaluation
Nasal blockage or mouth breathing					
Drainage out the front of nose					
Drainage down the throat					
Itching in the throat					
Itching/watery eyes					
Sneezing					
Cough					
Shortness of breath/asthma symptoms					
Headache					

Are you taking an antihistamine? ☐ Yes ☐ No *(check all tried)*

☐ Zyrtec ☐ Xyzal ☐ Allegra ☐ Claritin ☐ Loratadine ☐ Fexofenadine ☐ Benadryl

Are you taking a nasal steroid? ☐ Yes ☐ No *(check all tried)*

☐ Flonase ☐ Nasocort ☐ Nasonex ☐ Rhinocort ☐ Qnasl ☐ Omnaris

Is the site of your injection red or swollen? ☐ Yes ☐ No

Do you feel that your allergy shots are helping you? ☐ Yes ☐ No

Are you happy with your level of allergy symptom control? ☐ Yes ☐ No

Would you like to continue injections? ☐ Yes ☐ No

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