Allergy & ENT Associates

3901 Central Pike, Suite 351
Hermitage, TN 37076

920 S. Hartmann Dr, Suite 100
Lebanon, TN 37090

Name: _____ Age: _____ DOB_____ M / F Date: _____

Primary Doctor: _____ Referring Doctor: _____

Reason for visit: _____

CURRENT MEDICATIONS: (All medicines taken including over the counter, vitamins, supplements, and herbs)

Medication	Dose	Taken for	Medication	Dose	Taken for
1.			5.		
2.			6.		
3.			7.		
4.			8.		

PAST MEDICAL HISTORY: Have you ever had any of the following? Please circle yes or no for all questions.

Asthma	Y	N	Hiatal hernia	Y	N
Blood clot	Y	N	High blood pressure	Y	N
Blood clotting abnormality	Y	N	HIV/AIDS	Y	N
Cancer (type:_____)	Y	N	Irregular heart beat	Y	N
Diabetes	Y	N	Kidney disease	Y	N
Emphysema/COPD	Y	N	Peripheral vascular disease	Y	N
Gastroesophageal reflux	Y	N	Stroke	Y	N
Heart attack	Y	N	Thyroid Disease	Y	N
Heart valve problem	Y	N	Transfusions	Y	N
Hemophilia	Y	N	Tuberculosis (TB)	Y	N
Hepatitis A / B / C	Y	N	Ulcer	Y	N

Other medical conditions:_____

_____

MEDICATION ALLERGIES: List drug and type of reaction: _____

_____

PAST SURGICAL HISTORY: Check any you have had and give dates or further specifics if needed

___ Abdominal_____
___ Adenoidectomy_____
___ Back/Neck Spine _____
___ Brain _____
___ Cancer _____
___ Ear tubes _____
___ Heart/Lung _____
___ Hernia _____
___ Septoplasty _____
___ Sinus surgery _____
___ Neck/Thyroid/Parathyroid_____
___ OB/GYN _____
___ Orthopedic_____
___ Other ear surgery_____
___ Tonsillectomy_____
___ Voice Surgery_____

Please list other surgeries: _____

FAMILY HISTORY: Has any blood relative ever had:

Allergies	Y	N	Who?_____
Anesthesia complications	Y	N	Who?_____ If yes, please list type:_____
Free bleeding	Y	N	Who?_____
Hearing loss	Y	N	Who?_____
Thyroid disease	Y	N	Who?_____ If yes, please list type:_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: M S D W Separated

Are you exposed to loud noises?	Y	N	If yes, do you wear hearing protection? Y N
Do you smoke?	Y	N	If yes, how much?_____
Did you ever smoke?	Y	N	Year quit? _____
Other forms of tobacco or vape?	Y	N	If yes, what type? _____
Do you currently use alcohol?	Y	N	If yes, how much per day? _____
Problems with alcohol abuse?	Y	N	
Have you ever used illegal/recreational drugs?	Y	N	IV drugs? Y N

If yes, which ones_____

REVIEW OF SYSTEMS: Please circle any of these that you have experienced within the past 6 months.

Fatigue	Fever	Weight loss	Allergy shots	Allergy testing
Hives		Itching	Watery eyes	Hearing loss
Ringing in the ears		Ear pain	Ear pressure	Discharge from ear
Pulling at ears		Popping noise in ears	Decreased sense of smell	Nasal congestion
Nosebleed		Post nasal drip	Runny nose	Mouth breathing
Sneezing		Facial pain/pressure	Difficulty swallowing	Throat clearing
Enlarged tonsils		Heartburn	Sore throat	Voice problems
Lump in throat		Thyroid problems	Neck pain	Neck stiffness
Neck swelling		Swollen neck glands	Lymph node swelling	Chest pain
Irregular heartbeat		Shortness of breath	Wheezing	Coughing up blood
Jaw pain		Dizziness	Headache	Facial weakness