ENT & Allergy of New Orleans

urgENT

Patient Name: _____ **Date**: _____

Date of Birth: _____ **Primary Care Physician**: _____

Allergies ☐ None ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Latex

Other: _____

Medication(s) (including vitamins, supplements, and over the counter meds.): ☐ None

_____

_____

_____

Medical History ☐ None Other: _____

- ☐ ADHD
- ☐ Allergies / Hives
- ☐ Arrythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cholesterol
- ☐ COPD / Emphysema
- ☐ DVT
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ GERD (Reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV Positive
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Nasal Polyps
- ☐ Seizures
- ☐ Sinus
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid

Surgical History ☐ None Other: _____

- ☐ Appendectomy
- ☐ Breast Augmentation
- ☐ Ear Tubes
- ☐ Facial Plastics
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Heart Surgery
- ☐ Pacemaker / Defibrillator
- ☐ Sinus / Nose
- ☐ Tonsillectomy / Adenoidectomy
- ☐ Thyroid

Family History ☐ None Other: _____

- ☐ Allergies
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hearing Loss
- ☐ Migraines
- ☐ Stroke
- ☐ Premature Death

SEE BACK →

Social History:

Tobacco Use: Yes No Usage: <1 pack/day 1 pack/day >1 pack/day

Do others in the home smoke? Yes No

Alcohol Consumption: Yes No Daily 1-2 drinks/wk. 1-2 drinks/mth. 1-2 drinks/yr.

History of Substance Abuse or Recreational Drug use: Yes No

If yes, specify: _____

Please list all medical providers you see on a regular basis.

_____

_____

If you are having allergy symptoms, please circle all that apply below.

Environment:

Do you live in: Apartment Mobile Home House

Length you have lived there: _____

How old is the home: _____

Any pets in the home? Yes No If yes, what types? _____

Do you have a Dust Mite Cover on your mattress? Yes No

Are your pillows: Feathered Non-Feathered Unsure?

Are you comforters: Feathered Non-Feathered Unsure?

Do you have Central A / C or Window units?

Bedroom Flooring: Carpet Tile Laminate Wood

Area Rugs? Yes No

Patient or Parent Signature: _____