ENT Associates Southwest
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____First _____ MI _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

LIST ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS CURRENTLY TAKING:

Name of Medication	Dosage/How Often Taken	Why are you taking this medication?

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

Do you have any <u>non-medication</u> allergies?

Inhalant allergies (Please circle all that apply):

Air conditioning aromas of soaps/lotions animal exposure being indoors/outdoors exercise cigarette smoke other smoke and fumes cut grass dust mold pollen perfume

Food allergies or intolerances Y N **What foods? _____**

Contact allergies Y N **Circle:** iodine, latex, metal, tape _____

Contrast agent (dye) allergies Y N **Type: _____**

Insect bite or sting allergies (bees/spiders) Y N **Type**: _____

Allergy skin tests Y N **When/where**:_____

Allergy blood tests Y N **When/where**:_____

Allergy shots Y N **Where/how long on shots? _____**

Food allergy tests Y N **When/where: _____**