



ENT & ALLERGY CENTER OF AUSTIN

2765 Bee Caves Road, Suite 205, Austin, Texas 78746
1730 E. Whitestone Blvd., Suite 100, Cedar Park, Texas 78613
4112 Links Lane, Suite 204, Round Rock, Texas 78664

(512) 328-7722 (phone)
(512) 328-7724 (fax)
www.austinentmd.com

ENT PATIENT HEALTH HISTORY

Patient Name: _____ Gender: _____ DOB: _____

Pharmacy (Name & Address): _____

Primary Care Physician: _____

Height: _____ Weight: _____

Current Medications (list below or provide list):

Medication Name	Dosage	How Often Taken

Medication Allergies (list below or provide list):

Name of Medication	Type of Reaction

Non-medication Allergies (list below or provide list):

- Inhalant Allergies (dust, smoke, detergent, etc.) | List type & reaction: _____
- Food Allergies (beef, dairy, peanuts, etc.) | List type & reaction: _____
- Contrast Agent (dye used for radiology) | List Reaction: _____
- Insect Bite or Stings | List Type & Reaction: _____
- Past Allergy Test | When/Where: _____
- Past Treatment with Allergy Shots/Drops | When: _____
- Past Treatment for Food Allergy | When: _____

Past Medical History:

- No significant problems
- Hereditary/Congenital: _____
- Childhood Communicable Disease: _____
- Childhood Developmental History: _____
- Cancer: _____
- Head/Face (headache, etc.): _____



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- Eyes (cataracts, dry eyes, etc.): _____
- Ears (cerumen impaction, fluid, hearing loss, etc.): _____
- Nose (sinusitis, deviated septum, etc.): _____
- Mouth & Throat (tonsillitis, adenoid enlargement, etc.): _____
- Heart & Blood Vessels (Aneurysm, Angina, etc.): _____
- Lungs & Respiratory (Asthma, Pneumonia, etc.): _____
- Stomach & Digestive: (Ulcer, Hep B, etc.): _____
- Genitourinary (pregnant, etc.): _____
- Bones, Joints, Muscles: _____
- Skin (Psoriasis, etc.): _____
- Brain & Nervous System (Dementia, Stroke, etc.): _____
- Mental & Emotional (Depression, ADHD, etc.): _____
- Endocrine, Hormones, etc. (Diabetes, Obesity, etc.): _____
- Blood (HIV, Sickle Cell, etc.): _____
- Immune/Auto Immune (Sjogren's, Lupus, etc.): _____
- Other (not listed): _____

Surgeries & Hospitalizations:

- No surgeries or hospitalizations
- Please list: _____
- Any issues with anesthesia: _____

Serious Injuries:

- No serious injuries
- Head _____
- Neck _____
- Eye _____
- Ear _____
- Chest _____
- Back _____
- Bone _____

Family History:

- No Family History
- Mother's Side: _____
- Father's Side: _____



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Social History:

- Tobacco User Alcohol Consumption Recreational Drug Use Drug Dependence/Addiction
- Exposure Secondhand Smoke Other pertinent history: _____

Review of Systems:

- No problems (signs or symptoms)
- Constitutional Symptoms (chills, dizziness, fatigue, etc.): _____
- Eyes (blurred vision, itchy eyes, vision change, etc.): _____
- Ear (drainage, hearing loss, ringing, pressure, etc.): _____
- Nose & Sinus (congestion, obstruction, sneezing, etc.): _____
- Mouth & Throat (bad breath, snoring, sore, etc.): _____
- Cardiovascular (swelling, chest pain, etc.): _____
- Respiratory (coughing, pain, snoring, etc.): _____
- Gastrointestinal (blood, heartburn, etc.): _____
- Musculoskeletal (pain, stiffness, swelling, etc.): _____
- Integumentary (skin itching, lump, rash, etc.): _____
- Neurological (balance, spinning, etc.): _____
- Psychological (irritable, etc.): _____
- Endocrine (appetite change, hair loss, weight change, etc.): _____
- Hematologic (bruising, masses, swelling, etc.): _____
- Allergic/Infectious/Immunologic (hives, infections, sneezing, etc.): _____
- Other/Not listed: _____

Chief Complaint for Today's Visit:
