ALPINE
EAR, NOSE & THROAT, P.C.

ALPINE ALLERGY CLINIC
Adult and Pediatric Allergy Testing and Treatment

ALPINE ENT/ALLERGY PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____ Visit Date: _____

Gender: ☐Male ☐ Female ☐Other/Prefer not to state Reason for your visit today: _____

Primary Physician: _____ Referring Physician: _____

Pharmacy Preference: _____ Pharmacy Address: _____

Current Height: _____ Current Weight: _____

Social History & Health screening:

Do you have sleep apnea? ☐Yes, diagnosed with sleep study ☐Unsure ☐No

Tobacco Use: ☐None ☐ Current Smoker (#packs/day_____, # years smoked___) ☐Former smoker ☐Smokeless

Caffeine Use: ☐None ☐ # of drinks/day ___

Alcohol use: ☐None ☐ #of drinks/week ___ ☐ History of alcoholism

Other drug use: ☐Marijuana ☐ Vaping ☐Illicit drugs (specify): _____

Females age 65+: Have you ever had a bone scan (DXA Scan) to screen for osteoporosis? ☐No ☐Yes, I have

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Living Situation: ☐ Alone ☐ with spouse ☐ with children ☐ Assisted Living ☐Other: _____

☐ Will accept blood transfusion, if needed

Current Medications: Please list ALL medications you are currently taking	Dose	How Often Taken?

CONSENT TO ELECTRONIC PHARMARY BENEFITS DATA EXCHANGE: May we use Surescripts RxHub to review medications that have been prescribed to you by any provider? **Please initial:** YES: ____ No: _____

Medication Allergies ☐ No known drug allergies ☐ Yes, please list:	Type of reaction (rash, swelling, etc)

Non Medication Allergies: _____

ALPINE ENT/ALLERGY PATIENT HEALTH HISTORY, PAGE 2

Patient Name: _____ DOB: _____

Past Health History: Please check any that have been diagnosed now or in the past.

- ☐ ADHD
- ☐ Allergies (hayfever)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fib/Flutter
- ☐ Autoimmune disorder
- ☐ Breast cancer
- ☐ Cataracts
- ☐ COPD/emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Heart failure
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hyperthyroid (high)
- ☐ Hypothyroid (low)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Nasal Polyps
- ☐ Osteoporosis
- ☐ Otitis media (ear infections)
- ☐ Perforated ear drum
- ☐ Prostate Enlargement
- ☐ Pulmonary Embolism
- ☐ Reflux
- ☐ Recurrent tonsillitis
- ☐ Skin cancer
- ☐ Sinus infections
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Throat cancer
- ☐ TMJ (Jaw joint)
- ☐ Thyroid nodule

☐ History of bleeding or clotting problem. Please specify: _____

☐ Other, not listed above: _____

Past Surgical history (please list month and year of procedure):

History of problem with anesthesia. Please specify: _____

Ear surgery (eg. Ear tubes, Ear drum repair, Mastoid surgery): _____

Nasal surgery (eg. Septoplasty, Turbinate reduction, rhinoplasty): _____

Sinus surgery (eg. Balloon sinuplasty, sinus surgery, polyp removal): _____

Throat surgery (eg tonsils, adenoids, UPPP): _____

Neck surgery (eg. Thyroid, carotid surgery, tracheostomy): _____

Other (eg. Appendix, cataracts, gallbladder, heart surgery, heart stents, hemorrhoids, hernias):

_____

_____

_____

Family History: Have any family members been diagnosed with any of the following? Please check all appropriate.

	Father	Mother	Brother	Sister
Allergy				
Asthma				
Bleeding/clotting				
Diabetes				
Hearing loss before 50				

	Father	Mother	Brother	Sister
Heart Disease				
Heart attack				
Anesthesia prob				
Stroke				

Cancers (specify type): _____

Other: _____