Aspire Allergy & Sinus Health History Form

Patient Account #_____ Scope:_____ ENT:_____ CT:_____

Vial Prep (Per Unit): _____ Injection: _____ First Vial Prep Bill Est.: _____ Rel Qty: _____ SNOT Score: _____

Height: _____ **Weight:** _____ **BP:** _____ **HR:** _____ **Temp:** _____ **O_2:** _____ **RR:** _____

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____ Pharmacy: _____

CC: Reason for Today's visit (please specify how long you have had these symptoms):

_____

1. How long have you suffered with allergies?

_____

2. What are your main symptoms?

☐ Sneezing ☐ Coughing ☐ Wheezing
☐ Ear pain/congestion ☐ Headaches ☐ Watery/itchy eyes
☐ Sinus pain/pressure ☐ Congestion ☐ Hives
☐ Sleep Problems ☐ Runny Nose ☐ Nasal Drainage
☐ Loss of smell/taste ☐ Other _____

3. Are you currently on an Antihistamine? YES / NO

if yes, which one? _____

4. Do you use a Nasal Spray? YES / NO

if yes, which one? _____

5. Do you have symptoms year-round? YES / NO

worst season? ☐Spring ☐Summer ☐Fall ☐Winter

6. Have you had previous allergy testing? YES / NO

If yes, when and what type of known seasonal allergies?_____

_____

Any known food allergies? YES / NO

If yes, what food? _____

If yes, what type of reaction? _____

7. Have you had immunotherapy? YES / NO

If yes, which method; ☐Drops ☐ Shots

If yes, when was your last drop/injection? _____

If yes, how long was treatment?_____

If yes, why did you stop? _____

8. Ever had an anaphylactic reaction? YES / NO

If yes, when? _____

Did you to use/receive Epinephrine? YES / NO

Did you go to the hospital? YES / NO

9. Do you have pets (circle)? YES / NO

If so, what kind? _____

10. Have you ever had sinus/ENT surgery? YES / NO

If yes, what surgery? _____

If yes, when was the surgery? _____

Have you had a Sinus infection? YES / NO

If yes? ☐< 2 per year ☐≤ 4 per year ☐> 5 per year

Ever suffer from prolonged loss of smell? YES / NO

Ever have Pain/Pressure in face/sinuses? YES / NO

Have you taken Antibiotics this past year? YES / NO

If yes, which type? _____

Have you taken steroids this past year? YES / NO

If yes, which type? _____

11. Have you ever had Asthma? YES / NO

List any inhalers you use and how often?_____

_____

_____

Have you had to go to ER in the last year for asthma/SOB/wheezing? YES / NO

If yes, when? _____

12. Do you have any Drug Allergies? YES / NO

If so, to which drugs? _____

13. Any significant health conditions? YES / NO

If Yes, explain: _____

_____

_____

14. Are you currently pregnant or is there a chance of pregnancy? YES / NO

15. Please list any medications you are currently taking:

_____

_____

_____

_____