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NEW PATIENT FORM

Please complete as accurately and thoroughly as possible. Relate all answers to your own experiences.

Patient's name: ______________________________________ Preferred or nick name: _______________________

Address: ____ Apt #: _________________

City: ____ State: _______________________ Zip: _________________

Date of birth: ___________________________________ Social Security Number: _____________________________

Home phone: ____________________ Cell phone: _____________________ Business phone: ____________________

Email: ____

Parents' names (if patient is a minor): ____

Emergency contact: ____ Relation: _______________________________

Emergency contact phone number: ____

INSURANCE INFORMATION

Name of primary coverage: ____

Address: _________________________________ City: ______________________ State: ______ Zip: _____________

Subscriber name: ____ Date of birth: ____________________

Social security #: __________________________________ Employer: _______________________________________

Certificate number: __________________________________ Group number: _________________________________

Name of secondary coverage: ____

Address: _________________________________ City: ______________________ State: ______ Zip: _____________

Subscriber name: ____ Date of birth: ____________________

Social security #: __________________________________ Employer: _______________________________________

Certificate number: __________________________________ Group number: _________________________________

Primary Care doctor/pediatrician: _______________________________________ Phone: ______________________

Address: ____

Preferred pharmacy: ____ Phone: _________________________

Address: ____

How did you hear about us? ____

If referred, who referred you? ____

Describe the reason for your visit: ____

____

____

____

List the name and dates of all medications you have tried <u>for the above symptoms</u>: ____________________

____

____

____

List <u>all</u> chronic medical conditions:	**List <u>all</u> surgeries with approximate dates**:
______________________________	______________________________
______________________________	______________________________
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List any <u>drug</u> allergies with type of reaction: ____

____

____

____

____

List all <u>daily and as-needed</u> medications you are currently taking/prescribed <u>with dose and frequency</u> (include over-the-counter medications, inhalers, nasal sprays, eye drops, creams/ointments, epinephrine, etc.):

Medication:	**Dose:**	**Frequency:**
______________________________	______________	______________
______________________________	______________	______________
______________________________	______________	______________
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Social History

Occupation: ____ Employer: ____________________________________

Marital Status: _________________ Hobbies: ____

Are you a smoker? [ ]Never [ ]Current, everyday [ ]Current, some days [ ]Former smoker(what year did you quit?)_____

If you are a current or former smoker, how many packs per day: __________________ For how many years: _______________

Do you use: [ ]any other tobacco [ ]marijuana [ ]illicit drugs (if either of these, describe)? ___________________________

Do you drink alcohol (if so, what kind and how much): ____

Allergy Risks

House type: [ ]Apartment [ ]House [ ]Mobile home [ ]Condo [ ]Dorm **Approx age of home**: ___________

Heating: [ ]Electric [ ]Gas [ ]Fireplace [ ]None **Air Conditioning**: [ ]Central [ ]Window [ ]None

Mattress: [ ]Air bed [ ]Foam [ ]Spring [ ]Water bed **Pillow**: [ ]Feather [ ]Fiberfill [ ]Foam [ ]Other

Flooring in bedroom: [ ]Carpet [ ]Hardwood [ ]Tile [ ]Linoleum **Do you use a humidifier**: [ ]Yes [ ]No

How many of what type of pets do you have? [ ]None Dogs: _____ Cats: _____ Birds: _____ Chickens: _____ Horses: _____

How many smokers live in the household? __________________ **Do they smoke inside the house?** [ ]Yes [ ]No

When are your symptoms worse: [ ]Spring [ ]Summer [ ]Fall [ ]Winter [ ]All year long

If asthmatic, do any of these trigger your symptoms:[ ]Cold [ ]Heat [ ]Exercise [ ]Strong scents [ ]Illnesses

If asthmatic, please circle the answer for the following questions (choose only one answer for each question):

A. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?
1.All of the time **2**.Most of the time **3**.Some of the time **4**.A little of the time **5**.None of the time

B. During the past 4 weeks, how often have you had shortness of breath?
1.More than once a day **2**.Once a day **3**.Three to six times a week **4**.Once or twice a week **5**.Not at all

C. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?
1.Four or more nights a week **2**.Two to three nights a week **3**.Once a week **4**.Once or twice **5**.Not at all

D. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?
1.Three or more times per day **2**.One or two times per day **3**.Two or three times per day **4**.Once a week or less **5**.Not at all

E. How would you rate your asthma control during the past 4 weeks?
1.Not controlled at all **2**.Poorly controlled **3**.Somewhat controlled **4**.Well controlled **5**.Completely controlled

Are there any other allergy, asthma, or immunology concerns you have today? ______________________________
____
____
____
____
____

Family History:

Illness/Complaint	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daugther(s)	Grandparent(s)
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Environmental Allergy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Food Allergy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Eczema	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Hives	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

If anyone in your family have had the following, please indicate which family member:

Diabetes: _____________________________________ Heart disease: ___________________________________

Cancer: _______________________________________ High cholesterol: ________________________________

High blood pressure: ____

Autoimmune disease: ____

Other pertinent family history: ____

Review of Systems : Please check problems you have had recently (within 6-12 months)

Constitutional: [ ]Fever [ ]Fatigue [ ]Weight loss (unintended) [ ]Weight gain

Eyes: [ ]Itching [ ]Redness [ ]Watering [ ]Dryness [ ]Pain [ ]Loss of vision

ENT: [ ]Congestion [ ]Runny nose [ ]Post nasal drip [ ]Nosebleeds [ ]Sore throat [ ]Hoarseness

[ ]Snoring [ ]Itching [ ]Ringing in ears [ ]Ear popping [ ]Hearing loss [ ]Smell/Taste changes

Cardiovascular: [ ]Chest pain [ ]Palpitations [ ]Swelling of ankles

Respiratory: [ ]Cough [ ]Wheeze [ ]Shortness of breath [ ]Chest tightness

Gastrointestinal: [ ]Nausea [ ]Vomiting [ ]Diarrhea [ ]Constipation [ ]Abdominal pain [ ]Bloating [ ]Reflux

Genitourinary: [ ]Difficulty with urination [ ]Frequent urination [ ]Incontinence

Musculoskeletal: [ ]Joint pain [ ]Muscle pain [ ]Weakness

Skin: [ ]Itching [ ]Rash [ ]Hives

Neurologic: [ ]Headaches [ ]Numbness [ ]Tremor [ ]Difficulty sleeping [ ]Dizziness

Psychiatric: [ ]Anxiety [ ]Depression

Endocrine: [ ]Thyroid disease [ ]Diabetes

Hematologic/Lymphatic: [ ]Anemia [ ]Easy bleeding [ ]Easy bruising [ ]Swollen lymph nodes

Allergic/Immunologic: [ ]Frequent/persistent infections [ ]History of anaphylaxis (to what?)_______________

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Vitals: BP: _________ P: _________ RR: ________ Temp: ________ Ht: ________ Wt: ________ Pain: ________
CC: ____
General: ____
Eyes: ____ Ears: _____________________________________
Nose: ____ Oropharynx: ________________________________
Neck: ____ Lungs: ____________________________________
CV: ____ Abd: _____________________________________
Ext: ____ Psych: ____________________________________
MS: ____ Skin: _____________________________________
HPI: ____

Assesment/Plan: ____

____ **RTC:**_________________________________