New Patient Information

Name: _____ Regular Physician: _____Age: _____

Briefly describe the main reason for your visit today:

_____

_____

Allergy History:

Circle the following symptoms that you have or have had related to this problem.

Nasal congestion	*Bouts of sneezing*	*Runny nose*
Post nasal drip	*Nasal itching/rubbing*	*Bad breath*
Red eyes	*Itchy eyes*	*Frequent nosebleeds*
Sinus infections	*Discolored drainage*	*Popping in ears*
Bad taste in mouth	*Loss of smell*	*Headaches*

Please Circle things that make your symptoms worse:

Household dust *Feathers* *Animal dander* *Mold* *Mildew* *Damp areas*

Tree pollen *Grass* *Leaves* *Hay* *Colognes or perfumes* *Smoke* *Sun*

Exercise *Fatigue* *Change in temperature or humidity* *Weather changes*

Temperature changes *Time of day (AM/PM)* *Workplace* *Changes in season*

Respiratory History:

Circle the following symptoms that you have or have had related to this problem.

Cough	*Shortness of breath*	*Chest tightness*
Cough from post nasal drip	*Wheezing*	*Symptoms with exercise*
Waking up at night with symptoms	*Frequent oral steroids*	*Frequent inhalers*

Gastrointestinal History:

Circle the following symptoms that you have or have had related to this problem.

Vomiting	*Diarrhea*	*Abdominal pain*
Heartburn	*Regurgitation*	*Ulcer*

Skin History:

Circle the following symptoms that you have or have had related to this problem.

Hives	*Swelling*	*Itching*
Eczema	*Rash*	*Dry skin*

Environmental History:

How long have you lived in your current home? _____

Type of home: house / apartment / mobile home that is _____ years old.

Type of mattress: foam / innerspring / water bed. It is _____ years old.

Type of pillow: foam / feather / synthetic It is _____ years old.

Floors are mostly carpet / wood / linoleum / other

House is generally dry / dusty / moist / musty

Air conditioning is central / window units / not installed

Heating system electric / gas / oil / wood / kerosene

Change heat/air system filter every _____ months.

Any pets? Yes / No Types: _____ Indoors? Yes / No

Any smokers in the home? Yes / No Who? _____ Indoors? Yes / No

How many people in the household? _____

Anything unusual or remarkable about this home? _____

Please list all of your current medications here. (Include vitamins, supplements, herbs, etc):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Reaction History:

Any reactions to foods? _____

Any reactions to any medications:

_____

When did this occur? _____

What was the reaction?

_____

_____

Any reaction to insect sting and how it was treated:

_____

Past Medical History:

Have you ever been seen by an allergist? Yes / No Who? _____ When? _____

Have you ever been seen by an ENT? Yes / No Who? _____ When? _____

Have you ever been on allergy shots? Yes / No When? _____ How long? _____

Any chronic health problems or diagnoses?

_____

Family Health History:

Describe any allergic symptoms or asthma in family members (hay fever, asthma, sinus problems):

Social History:

Occupation? _____ Student? Yes / No

Briefly describe your work/school environment:

_____

Tobacco use? Yes / No How long? _____

Hobbies? _____