

**NEW PATIENT INFORMATION FORM**

Failure to produce payment at check-in may result in your appointment  
We accept cash, check and credit card. (Visa, MasterCard and Discover)

**All information reviewed by:**

**Patient's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female **Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Language 1:** \_\_\_\_\_ **2:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Family Doctor/Pediatrician:**

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**If the patient is a minor (under 18) please complete:**

**Father's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**If referred, who referred you?** \_\_\_\_\_

**PATIENTS UNDER AGE 18 MUST BE ACCOMPANIED BY A PARENT OR DESIGNATED ADULT IN ORDER TO BE SEEN.**

**In order to provide a high quality initial assessment, we schedule a lengthy first appointment for our new patients. If you are unable to keep this scheduled appointment, we require a 24 hour cancellation notice. If a cancellation notice is not given 24 hours in advance, a \$40.00 administrative fee will be charged.**

**The patient is responsible for:**

**PLEASE DO NOT WEAR FRAGRANCES**

Please describe in your own words the reason for your visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EVALUATION FOR ASTHMA:**

At what age were you diagnosed with asthma? \_\_\_\_\_

Have you had any hospitalizations or ER visits for asthma? Yes No

If yes, list approximate dates: \_\_\_\_\_

Have you been treated with steroid pills for asthma? Yes No

If yes, how often? \_\_\_\_\_ When was the last time? \_\_\_\_\_

Have you been prescribed any of the following inhalers?

- Advair Symbicort Dulera Flovent
- Asmanex QVAR Pulmicort Alvesco Aerobid Azmacort

What symptoms of asthma do you experience?

- Cough Wheeze Shortness of breath Chest tightness

How many days per week do you experience these symptoms? \_\_\_\_\_

How many days per week do you use a rescue inhaler? \_\_\_\_\_

How many nights per month does your asthma hinder your ability to sleep? \_\_\_\_\_

- What triggers your asthma? Exercise Laughter Crying Cold Heat Respiratory infections  
Change of seasons Pollens Animals Dust Mold Strong smells (tobacco, perfumes, detergents, etc.)

**EVALUATION FOR HAY FEVER:**

Check the following symptoms that affect you:

- Sneezing Runny nose Stuffy nose Post nasal drip Itchy eyes
- Itchy ears Itchy nose Itchy throat Watery eyes Swollen eyes None

When do these symptoms bother you?

All year long Certain months only (list): \_\_\_\_\_

What exposures make these symptoms worse? Indoors Outdoors

Strong smells (perfumes, cleaning detergents, etc.) Rainy days Dry & windy days

Cats Dogs Dust Molds Feathers/Birds

What medications have you tried? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EVALUATION FOR SINUSITIS:**

Do you struggle with frequent sinus infections? Yes No If yes, how many in a given year? \_\_\_\_\_

Have you ever had nasal polyps? Yes No

Have you lost your sense of smell or taste? Yes No

Have you ever had sinus surgery? Yes No If yes, list dates: \_\_\_\_\_

**EVALUATION FOR HEADACHES:**

Do you struggle with headaches?  Yes  No

If yes, check the description of the headaches that apply:

- Pulsating pain  Constant pain  Associated with intolerance of loud sounds or bright lights
- Worse with physical exertion  Duration > 4hrs  Debilitating
- Located only on one side of the head  Located on both sides of the head

**EVALUATION FOR HIVES:**

When did current bout of hives start? \_\_\_\_\_ How often are they occurring? \_\_\_\_\_

How long does each individual hive last? \_\_\_\_\_

Are the hives intensely itchy?  Yes  No

Do the hives leave dark marks?  Yes  No

Have you had any illness before onset of hives?  Yes  No

Do you suspect any food triggers?  Yes  No

If yes, what foods? \_\_\_\_\_

Do you take any ibuprofen or ibuprofen-like medications?  Yes  No

If yes, list: \_\_\_\_\_

Have you noticed hives to be worse with the following?

- Heat  Cold  Exercise  Scratching  Stress  Showers
- Menses  Alcohol  Pressure on the skin (such as waist band/bra strap areas)

Have you ever had hives before in your lifetime?  Yes  No

Have you had swelling?  Yes  No

Have you noticed any of the following?

- Throat closing  Shortness of breath  Change in your voice
- Tongue swelling  Sensation of something stuck in your throat

**OTHER ALLERGIC HISTORY:**

Do you have food allergies?  Yes  No

If yes, list each food or meal and the reaction you had to it:

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Have you had any problems after bee or wasp stings?  Yes  No

If yes, describe the reaction (Do not include reactions to mosquito bites):

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Do you have any drug allergies?  Yes  No If yes, list each medication and describe the reaction:

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Do you have a history of latex allergy?  Yes  No If yes, describe the reaction:

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Do you have a history of eczema?  Yes  No

**MEDICATIONS:**

List all medications you currently take (include all over-the-counter medications, eye drops, nasal sprays, inhalers, birth control pills, digestive aids, vitamins, supplements, aspirins, etc.)

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**MEDICAL HISTORY:**

Please list all chronic medical conditions:

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Please list all surgeries and hospitalizations with dates:

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**FOR CHILDREN UNDER 15:** What was the birth weight? \_\_\_\_\_

Were there any complications before, during or after the delivery?  Yes  No

If yes, please explain: \_\_\_\_\_

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Has growth and development been normal?  Yes  No

If no, please explain: \_\_\_\_\_

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**FAMILY HISTORY: Illness/Complaint**

Asthma  Hay Fever  Food Allergy  Drug Allergy  Eczema  Hives  Headaches

**Father Mother Brother(s) sister(s) other:** \_\_\_\_\_

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**ENVIRONMENTAL SURVEY:**

What type of heating/cooling system do you have in your home?

- Forced air  Radiator  Baseboard heat  Central air  
 Window units  Wood burning heat  Fans

Does anyone in your household smoke?  Yes  No If yes, where?  Indoors  Outdoors

Are there any obvious mold problems?  Yes  No

Do you use humidifiers?  Yes  No

Is there wall to wall carpeting?  Yes  No If yes, which rooms? \_\_\_\_\_

Do you use feather pillows?  Yes  No

Do you have down comforters or down coats?  Yes  No

List any family pets: \_\_\_\_\_

Are there any young children in your home?  Yes  No If yes, list ages: \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

How much alcohol do you drink and how often? \_\_\_\_\_

Do you, or did you ever, smoke?  Yes  No

If yes, how many packs per day on average? \_\_\_\_\_ For how many years? \_\_\_\_\_

If you no longer smoke, when did you quit? \_\_\_\_\_

Do you exercise regularly?  Yes  No

If yes, what type of exercise? \_\_\_\_\_

**REVIEW OF SYMPTOMS:**

**General:**  Chills  Fatigue  Fever  Night sweats  Weight gain  Weight loss  Dryness

Pain  Persistent hives  None

**Eyes:**  Redness  Vision changes  None

**Ears:**  Hearing loss (*circle one*) L R Both  Fullness  Ringing  None

**Nose:**  Bloody nose  Discolored discharge  Sense of smell  Sinus pressure  None

**Mouth/Dental:**  Sense of taste  Thrush  Oral ulcers  None

**Cardiovascular:**  Chest tightness  Cough  Shortness of breath  Wheeze  None

**Respiratory:**  Chest pain  Palpitations  None

**Digestive:**  Abdominal pain  Excessive burping  Bloating  Diarrhea  Indigestion  Nausea  None

**Musculoskeletal:**  Leg swelling  Muscle aches  Numbness  Joint pain  Tingling  Weakness  None

**Skin:**  Rash  Brittle hair  None

**Neurological:**  Headache  Lightheadedness  Loss of consciousness  None

**Psychological:**  Anxiety  Depression  Sleep pattern disturbance  None

**Endocrine:**  Hot flashes  Excessive sweating  Irregular Menses  Unusual weight gain or loss

Low sexual desire  None