NEW PATIENT INTAKE SHEET

Allergy and Asthma Center
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DATE: _____

PATIENT NAME: _____

PHONE NUMBER: _____

ARE YOU TAKING A BETA BLOCKER: YES: _____ NO: _____

IF SKIN TESTING, HAVE YOU HAD AN ANTIHISTIMINE WITHIN THE PAST 5 DAYS?

YES: _____ NO: _____

VITALS (For office use only):

BP: _____HR: _____TEMP: _____HEIGHT: _____ft. _____in. WEIGHT: _____lbs.

PATIENT INFORMATION:

PATIENT DOB: _____

PRIMARY CARE PHYSICIAN:

_____

REASON FOR VISIT: _____

PLEASE LIST YOUR OCCUPATION:

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS/LATEX? (Please list):

1) _____ 3) _____
2) _____ 4) _____

LIST ANY MEDICATIONS TAKING TO INCLUDE "OVER-THE-COUNTER" MEDICATIONS (To include dosage/frequency):

1) _____ 3) _____
2) _____ 4) _____

DO YOU HAVE ANY MEDICAL CONDITIONS (Please list):

_____

HAVE YOU EVER BEEN HOSPITALIZED/HAD ER VISITS/ANY SURGERIES? (Please list):

_____

DO YOU HAVE ASTHMA/BEEN HOPSPITALIZED/HAD ER VISITS FOR ASHTMA? IF YES, PLEASE LIST WHEN YOUR LAST SYMPTOMS WERE AND DATES OF HOSPITALIZATION:

_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

- Eczema: _____ _
- Ear Infections (How many): _____
- Bronchitis (Average number/Year or total):_____
- Sinus Infections (Average number/Year or total): _____
- Strep Throat or Pharyngitis (Average number/Year or total):_____

HOW OLD IS YOUR HOME: _____ HOW OLD IS YOUR CARPET: _____

DO YOU LIVE WITH ANY PETS? (If yes, please list how many and what type):

_____

HAVE YOU EVER AND/OR USED TOBACCO PRODUCTS? YES_____ NO_____

(IF YES) WHEN? : _____

IS THERE ANY TOBACCO EXPOSURE IN YOUR HOME AND/OR WORK? YES_____ NO_____

DO YOU DRINK ALCOHOL? YES_____ (If yes how often) _____ NO_____

LIST ALL MEDICAL CONDITIONS THAT EXIST IN YOUR FAMILY INCLUDING WHO HAS THEM:

_____

_____

_____

Pharmacy Name: _____ City/State: _____

Pharmacy Number: _____

ARE YOUR IMMUNIZATIONS UP TO DATE? YES: _____ NO: _____

SYSTEM REVIEW: (Please circle any of the following symptoms/condition that you have):

- Blurry Vision/Visual Problems
- Heartburn
- Abdominal Pain
- Thyroid Problems
- Gas/Bloating/Flatulence
- Cold/Heat Intolerance
- Diarrhea/Constipation
- Sneezing/Nasal Congestion/ Runny Nose
- Wheezing
- Itchy Eyes
- Cough
- Musculoskeletal Pain
- Pain/Swelling of Joints
- Rash/Skin Problems
- Hair Loss
- Numbness of Extremities
- Difficulty in Urination
- Back Pain