

New Patient History

Patient's Name: _____ **DOB:** _____ **Date of visit:** _____

Main reasons for your visit: _____

Referring physician: _____

Main symptoms: (please circle & fill out left side only) Is a family member our patient? yes / no

Nose: itchy, sneezing, runny, stuffy, mouth breathing, post-nasal-drip, ↓ smell, snoring, nosebleeds

Sinuses: headaches, facial pain, recurrent infections, frequent sore throat, hoarseness, loss of voice
of sinus infections last year: _____ Last sinus x-ray or CAT scan: _____

Eyes: itchy, watery, red, swelling/puffiness, pain, dark circles, glaucoma, cataract

Ears: itchy, pain, popping, fullness, dizziness, ringing, recurrent infections, decreased hearing

Cough: dry hacking, productive of sputum **Worse at:** night, morning, all the time, laughing, exercise

Chest: shortness of breath, chest tightness, wheezing, chest congestion, chest pains, asthma, bronchitis, pneumonia, cough or wheeze at night, cough or wheeze with exercise, chest colds

How often do you cough or wheeze? _____ Diagnosed with asthma? never / what age? _____
of ER visits: _____ # of hospitalizations: _____ Last chest X-ray: _____

Does asthma restrict your physical activity (exercise, housework, yard work, etc): yes / no

Do you use any inhaler before exercise? yes / no Type of regular exercise: _____

Stomach: cramps, indigestion, heartburn, gastric reflux, hiatal hernia, vomiting with severe cough

Skin: general itching, rash, hives, swelling, eczema, poison ivy, earrings, nickel, latex glove allergy

Food allergy: (list if any) _____

Insect allergy: yes / no; **if yes:** local reaction, generalized hives, hospitalized

Other: poor sleep, excessive fatigue, sadness, worthlessness, low concentration, restlessness

How long have you had these symptoms? _____ Worse: _____ days/months/hrs

Do allergies interfere with your life style? _____

How many school or work days have you missed in the past year: _____

Previous skin testing & treatment: yes / no If yes, when? _____

Where & by whom? _____

Main positive reactions: _____

Received allergy shots? yes / no If yes, how long? _____ # of shots each visit? _____

Currently on shots every _____ wks Did shots help? yes / no Any reactions? _____

Aggravating factors: (please circle)

Worse: spring, summer, winter, fall, year around, at home, at work, morning, evening, night, house dust, pollens, mowing grass, raking leaves, cat, dog, birds, feathers, horses

infections, rainy days, cold weather, hot humid weather, sudden temp. change, cigarette smoke

strong odors, cosmetics, perfumes, fumes, paints, soap/detergents, cleaning products,

food additives, dried fruits, wine, beer, Aspirin, Motrin, Ibuprofen, other medications

Are you exposed to preschoolers at home? yes / no At work? yes / no

Headaches: (skip to next section if you don't have headaches)

Type of headaches: sinus, tension, migraine, associated with menses

How often: _____ wk/month/yr **Time of day:** all day, morning, afternoon, at night

Location? frontal, temple area, behind eyes, back of head **Since when?** _____

Associated symptoms: nausea, vomiting, vision changes, sensitivity to light or sound

Triggers: stress, weather changes, cigarette smoke, strong odors, menses, allergies flare-up

Medications, which helped: _____

Rash/Hives: (skip to next section if you don't experience rashes)

Duration of rash? _____ **Is rash?** constant, intermittent

Body parts typically affected? scalp, face, neck, chest, abdomen, arms, legs, hands, feet

Swelling? none, lips, eyes, throat/tongue, other _____ **Difficulty in breathing?** yes / no

Onset? sudden, gradual, over minutes, over hours, over days

Disappears? over minutes, over hours, over days **Suspect any food or drugs?** yes / no

Triggers: not sure, stress, heat, cold, sunlight, sweating, exercise, cold water, foods,

latex contact, detergents, soaps, make-up, deodorant, new clothes, perfumes, minor trauma

Associated symptoms: fever, chills, diarrhea, headache, weight loss, heat or cold intolerance

Visits required, if any? ER, urgent care, primary doctor, hospitalization, none

Treatment received so far? _____

Physician Notes

Blank lined area for physician notes.

