NEW PATIENT INFORMATION

Date of Visit: ________________

Name: ______________________________________ Age: ____________ Date of Birth: ________________

Phone: Home (   )__________________________ Work: (   ) ________________________

Primary Care Doctor: __________________________ Referring Doctor: ______________________________

Pharmacy: ___________________________ Phone #: ______________

Briefly describe your main reason for today's visit:_____________________

____

____

How long have you had these problems?___________________________

How frequently do you have them?________________________________

PROVIDER COMMENTS
(Do not write in this space)

I was asked to see this pt in consultation by

Dr.______________________for

______________________________ .

I. ALLERGY HISTORY

Nasal Symptoms/Causes

1. I have the following symptoms (circle all that apply and star the most troublesome one or ones):

nasal congestion	nasal itch/rub	bad breath
fatigue/irritability	red eyes	snoring
post nasal drip	itchy eyes	mouth breathing
runny nose	sinus infections	nosebleeds
sneezing	discolored drainage	loss of taste/smell
nasal polyps	headaches	

2. Circle all the things that cause your symptoms (circle all that apply and star the most troublesome):

dust	mold/mildew/	time of day - am/pm
fall pollen	mustiness/dampness	home
springtime pollen	indoors	workplace
cut grass/rake leaves	outdoors	food______________
dog	weather changes	rain
cat	smoke	
other animals________	strong odors	
feathers	temperature changes	

Do your symptoms occur year round or seasonal? Circle one or both

If seasonal, months symptoms occur: ______________________________

3. Have you had sinus x-rays or CT Scan? Yes No

II. RESPIRATORY HISTORY

1. Circle any appropriate symptoms.

cough	cough from post nasal drip	wheeze
tightness	symptoms with exercise	shortness of breath

If you circled any of the above symptoms, complete questions 2-8

2. Do you wake up at night because of chest symptoms? Yes No
   times per week/month ______________
3. Did you have problems with your breathing at birth? Yes No
   If yes, explain:
4. Breathing problem is triggered by:

pollen	exercise	colds	sinus infections
mold	heartburn	pets	cold weather
foods	weather change/rain	other ______________	

5. Circle any circumstance appropriate to your asthma.
   ER visits Hospitalization Intubation ICU admission Pneumonia
6. Have you been on steroids or received a steroid shot for your asthma? Yes No
   If yes, how many times in the past 12 months? ________
7. Have you had a chest x-ray? Yes No Last X-ray: ____________

III. MEDICATIONS

I take the following medications, including inhalers and nasal sprays:

Name	Dose	Frequency used	
____	____	____	daily/often/rarely
____	____	____	daily/often/rarely
____	____	____	daily/often/rarely

Other medications:

____ ____ times a day/week/month
____ ____ times a day/week/month
____ ____ times a day/week/month
____ ____ times a day/week/month

1. Do you use a spacer with your inhaler? Yes No
   If yes, which type? ____
2. Do you own a home nebulizer? Yes No
3. Do you own a peak flow monitor? Yes No
   If so, please list your best peak flow rate ____

IV. PREVIOUS ALLERGY EVALUATION

Have you ever had allergy skin testing? Yes No
If yes, when ____
Were you on allergy injections? Yes No
If yes, when ____ Did they help? Yes No

V. ENVIRONMENTAL SURVEY - HOME

General (Circle where appropriate)

1. Where do you live? House Apartment Trailer Condo Other
2. How long have you lived there? ____ How old is it? ____
3. Pets (If yes, please specify): Yes No
   - Cat indoor outdoor both
   - Dog indoor outdoor both
   - Other indoor outdoor both
4. Smokers in the house? Yes No
5. Is your home air conditioned? Yes No If yes, central or window?
6. Do you keep your windows closed? Yes No
7. Do you have a humidifier? Yes No if yes, central or room?
8. Do you have an electrostatic air filter? Yes No
9. Do you have moisture problems in your home? Yes No
10. Do you have a basement? Yes No Is it damp? Yes No

Bedroom

1. Type of bed? Regular Waterbed/waveless Waterbed/wave
2. Plastic encasement of mattress? Yes No On pillow? Yes No
3. Stuffed animal in bedroom? Yes No How many? ____
4. Type of pillow: Feather Synthetic Cotton
5. Do you have: Carpet Wood Vinyl flooring

VI. WORK/SCHOOL

1. What is your occupation? ____
2. A student? Yes No What grade are you in? ____
3. What are your hobbies? ____
4. Are your symptoms worse at work? Yes No
5. Do you get better on vacation? Yes No
6. How many days did you miss school or work in the past year? ____
7. If child, is he/she in daycare? Yes No
8. How many children in room? ____

How long have you lived in Georgia? ____ years
Where else have you lived? ____

VII. FAMILY HISTORY

Does any member of your family have a history of:

	Who: (father, mother, grandmother, etc.)
Asthma	____
Hay fever	____
Eczema	____
Migraines	____
Recurrent infections	____
Cystic Fibrosis	____
Insect Sting Reactions	____
Other	____

PROVIDER COMMENTS
(Do not write in this space)

VIII. GENERAL MEDICAL HISTORY

HOSPITAL STAYS?

Date ______________ Reason ______________

PROVIDER COMMENTS
(Do not write in this space)

MEDICAL PROBLEMS

Review of Systems - Please circle any appropriate problems

Constitutional: fever weight loss weight gain fatigue irritability

Eyes: swelling around eye discharge contact lens glaucoma cataracts

HENT: hearing loss recurrent ear infections hayfever runny/itchy nose

Cardiac: palpitations chest pain high blood pressure heart disease

GI: nausea vomiting heart burn stomach pain diarrhea liver disease ulcer

gu: pain of urination difficulty urinating frequent urination blood urinary infections prostate problems

Musculoskeletal: joint swelling bone pain frequent broken bones osteoporosis
Is child growing well? Yes No

Skin: eczema hives itching sores in mouth thrush

Neurologic: headaches numbness seizures weakness migraines

Psychiatric: Allergies affecting the quality of life? Yes No

Hematologic: anemia swollen glands bleeding HIV positive

Other Problems (circle all that apply)

Arthritis	Diabetes	Thyroid disease
Cancer	Tuberculosis	Bowel disease
Asthma	Allergies	Hayfever

SURGERY / OPERATIONS

Which ones and what year? ______________

Ear tubes Nasal/Sinus surgery Tonsillectomy/Adenoidectomy

Other ______________

Have you had chicken pox? Yes No Vaccine

SMOKING HISTORY Yes No How much? ______________

For how many years? ______________

When did you stop? ______________

Have you had all your childhood immunizations? Yes No

Do you get a flu shot every year? Yes No

Have you had the Pneumovax vaccine? Yes No

IX. MEDICATION ALLERGY

Medication	Reaction	Date

X. OTHER ALLERGIES

Do you have eczema or hives? (circle) Yes No

Have you ever had an allergic reaction to an insect sting? Yes No

If yes, what happened? ______________

Are you allergic to any foods?

Food	Reaction	Date

Have you ever had itching, sneezing or swelling after dental exam or GYN exam? Yes No

Have you ever had a reaction after using any of the following? (circle)

Balloons rubber products elastic bandages condom

Urticaria / Angioedema Section

(only fill out if you are being seen for Hives or Swelling)

PROVIDER COMMENTS
(Do not write in this space)

1. How long have you had hives / swelling? ______________________
2. Briefly describe the circumstances surrounding their onset:
____
____
____

2a. How often have you had hives? ______________________

3. What medications are you taking for the hives / swelling? ______________________
____

4. How long does each individual hive last? <24 hours >24 hours
5. Do they itch? Yes No
6. Are they painful? Yes No
7. Do you experience shortness of breath, wheeze, chest tightness, abdominal pain, throat fullness, dizziness or diarrhea? (circle appropriate symptoms)
Yes No
8. Have you recently experienced fevers, chills, night sweats, swollen glands, swollen joints, weight gain or loss? (circle appropriate symptoms)
Yes No
9. What "triggers" the hives / swelling (circle)

stress	vibration	exercise	medications
friction	home	food	pressure
work	heat	sunlight	cold
water	other	do not know	

11. Do you have a family history of hives / Angioedema? Yes No
Who? ______________________
12. Have you ever had hives / angioedema in the past? Yes No
If yes, when & how long did they last? ______________________

Insect Section

(only fill out if you are being seen for Insect Allergy)

1. My reaction to an insect sting occurred on: Month________Year _________
2. Please describe the location of sting and what happened at the time of the sting.
____
____
3. What caused the sting? Bee Wasp Yellow Jacket Hornet Ant Unknown
4. The symptoms that occurred after the sting included (please circle)

swelling at the site	trouble breathing
distant swelling (i.e. lips, tongue)	trouble swallowing
hives	vomiting
loss of consciousness	dizziness

5. I received treatment at an emergency room Yes No
If yes, which one? ______________________
They gave me Benadryl Epinephrine Steroids IV fluids I don't know
6. I have an Epi pen. Yes No
7. Have you ever been stung before? Yes No
If yes, when and describe the reaction ______________________
____
____

ATLANTA ALLERGY & ASTHMA