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New Patient History Form

Name:_____ **DOB:**_____

Reason for visit: _____

Signs and symptoms: Please circle + (yes) or – (no), approximate the duration (eg. 2 days, 3 weeks, 1 year, occasional, etc.) and if applicable, circle the seasons you experience the symptom.

		Duration	Season			Duration	Season
Runny nose	+ -		SP SU F W	Fever /Temp=_____F	+ -		SP SU F W
Itchy eyes	+ -		SP SU F W	Chills	+ -		SP SU F W
Sore throat	+ -		SP SU F W	Sweats	+ -		SP SU F W
Post nasal drip	+ -		SP SU F W	Fatigue	+ -		SP SU F W
Nasal/sinus congestion	+ -		SP SU F W	Muscle aches	+ -		SP SU F W
Snore	+ -		SP SU F W	Joint pain	+ -		SP SU F W
Decreased sense of smell	+ -		SP SU F W	Rash or hives	+ -		SP SU F W
Headache	+ -		SP SU F W	Itchy skin	+ -		SP SU F W
Earache	+ -		SP SU F W	Nausea/Vomiting/Diarrhea	+ -		SP SU F W
Cough	+ -		SP SU F W	Heartburn	+ -		SP SU F W
Wheeze	+ -		SP SU F W	Other_____	+ -		SP SU F W
Shortness of breath	+ -		SP SU F W	Other_____	+ -		SP SU F W

Past Medical History: (Check if any have ever applied to you & specify if needed)

___**Premature birth (**Gestational age _____)
___**Breast fed** (Number of months_____)
___**Eczema (** ___Infant ___Child ___Adult)
___**Food allergy (_____)**
___ **Allergies** __Pollen___Pets___Dust___Mold
___**Drug allergy** (list reaction and approx. age)
__Penicillin (_____)
__Other (_____)
___**Insect allergy**
___**Anaphylaxis**
___**Hives**
___ **Angioedema (swelling)**
___**Asthma**
___**Bronchitis**
___**Pneumonia**
___**COPD**
___**Other lung problem (**_____)
___**Recurring infections**
___**Ear infections** ___Child ___Adult

___**Sinus infections**
Date of last bout_____
Med. Taken_____
___**Nasal polyps**
___**Acid Reflux (GERD)**
___ **Psychiatric problem (_____)**
___**High blood pressure**
___**High cholesterol**
___**Heart disease** (_____)
___**Diabetes**
___**Thyroid problem**
___**Autoimmune/rheum. (_____)**
___ **Prostate problem**
___ **Glaucoma**
___**Kidney problem (_____)**
___**Liver problem (_____)**
___**Blood problem (_____)**
___**Orthopedic (_____)**
___**Chronic pain (_____)**

___**Cancer**
Type_____
Year of remission_____
___**Emergency room visits**
Ages_____
Reasons_____
___**Hospitalization**
Ages_____
Reasons_____
___**Intensive care unit**
___Intubation/ventilator
___**Surgery**
___Tonsils ___ Ear tubes
___Adenoids ___Sinus
Others_____
_____
___**Smoker**
years____ Year Quit_____
___**Other** (_____)

Current Medications:_____

_____

Last sinus CT scan: Date_____ Location_____
Last Chest X-ray: Date _____ Location_____
Last Blood Draw: Date _____ Location_____

Family history: (Check if applies to anyone in your immediate family)

___ Allergies ___ Autoimmune disease (thyroid, lupus, MS, rheum. arthritis, etc.) ___Angioedema (swelling) ___ Nasal polyps
___ Asthma ___ Sinus problems ___ Cancer
___ Other lung problems ___ Celiac disease (Gluten problem) ___Eczema ___ Glaucoma

Enviromental exposure: (Check if applies to you)

___Carpeting in the bedroom
___Pets (Types and #_____)
___Open windows (at home on a nice day)
Occupation_____
___Daycare (age at first exposure _____)
___School (Grade_____)
___Play sports/exercise– Problems with endurance Y N
___Children/grandchildren: Ages _____