**PANACEA ALLERGY**
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# New Patient History Form

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**Name:**____________________________________**DOB:**__________ **Date of Service:**__________

**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.

| Symptom | +/- | Duration | Season | Symptom | +/- | 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
___ Asthma
___ Other lung problems
___ Autoimmune disease (thyroid, lupus, MS, rheum. arthritis, etc.)
___ Celiac disease (Gluten problem)
___Angioedema (swelling)
___ Sinus problems
___Eczema
___ Nasal polyps
___ Cancer
___ 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 __________________