

McGOVERN ALLERGY and ASTHMA CLINIC, P.A.

PATIENT NO. _____

PATIENT INFORMATION SHEET

DATE _____

* PLEASE PRINT *

* PLEASE PRINT *

<input type="checkbox"/> DR. <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS	PATIENT'S NAME	LAST	FIRST	MIDDLE	BIRTHDATE	Marital Status	AGE	SEX
					/ / Mo. Day Yr.			
HOME ADDRESS		STREET	CITY	STATE	ZIP	Patient's Social Security No.		
						— —		
MAILING ADDRESS		STREET	CITY	STATE	ZIP	Patient's Home Phone No.		
						() —		
E-MAIL						Cell Phone No.		
						() —		
OCCUPATION			PLACE OF EMPLOYMENT			Business Phone No.		
						() —		
EMPLOYER'S ADDRESS			CITY	STATE	ZIP			
SPOUSE'S FULL NAME			OCCUPATION	PLACE OF EMPLOYMENT				
ADDRESS OF SPOUSE'S EMPLOYER				CITY	STATE	ZIP	Business Phone No.	
							() —	
CHIEF PROBLEM								
REFERRED BY	NAME	ADDRESS		CITY	STATE	ZIP		
PATIENT'S FAMILY PHYSICIAN'S NAME		ADDRESS		CITY	STATE	ZIP	PHONE #	
EMERGENCY CONTACT								
NOT LIVING WITH YOU _____ PHONE NO. _____ RELATIONSHIP _____								

INSURANCE COMPANY	INSURED'S NAME
GROUP NUMBER	POLICY NUMBER
EMPLOYER	VERIFICATION PHONE NO.
MEDICARE NO.	MEDICAID NO.

PLEASE COMPLETE THE FOLLOWING IF PATIENT IS A MINOR OR DEPENDENT

FATHER'S FULL NAME	PLACE OF EMPLOYMENT	Business Phone No.
		() —
HOME ADDRESS		Home Phone No.
		() —
MOTHER'S FULL NAME	PLACE OF EMPLOYMENT	Business Phone No.
		() —
HOME ADDRESS		Home Phone No.
		() —
OTHER (<i>Legal Guardian, Foster Parent, Power of Attorney, Institutional Representative</i>)	PLACE OF EMPLOYMENT	Business Phone No.
		() —
HOME ADDRESS		Home Phone No.
		() —

PLEASE SIGN:

NAME:

DATE:

PATIENT NO:

AGE:

ADDRESS:

DATE OF BIRTH:

Chief Complaint:

(Reason for coming in)

Check where applicable:

Nose/Ears/Eyes/Throat Symptoms

First noticed _____

- Sneezing
- Runny nose
- Nasal congestion
- Nose bleeding
- Loss of smell
- Nasal polyps
- Postnasal drainage
- Frequent sore throat
- Cough
- Frequent respiratory infections
- Earaches
- Ear infections
- Hearing loss
- Vertigo (dizziness)
- Itchy, watery eyes

Worst season _____

Skin/Eczema

- Rash
 - red
 - swollen (raised)
 - blisters (fluid filled)
 - itchy
 - scaly, dry
 - infection

Location on body _____

Any known cause(s) _____

Precipitating Factors: (check if symptoms are worsened or affected by)

- Weather change
- Rainy days
- Foggy days
- Fumes
(Insecticides, chemicals, tobacco smoke)
- Physical exertion
- Musty odors
- Perfume or cosmetics
- House cleaning, moving
- House dust
- Mowing the lawn
- Infection
- Change of locale
- Newsprint

Medications:

Allergy medications (list all past and current medications given for allergy and state which ones were helpful)

List other current (non-allergy medications)

Headache Symptoms

First noticed _____

- sharp
- dull
- pressure
- vise-like

Location _____

Frequency _____

Time headache worse _____

Any known cause(s) _____

Treatment(s) tried _____

Associated symptoms such as sinusitis _____

Hives and/or Swelling

Hives

Location _____

Swelling

Location _____

First noticed _____

Duration _____

Associated symptoms _____

Chest Symptoms

First noticed _____

- Cough
sputum color _____
- Wheeze
- Tight chest
- Attacks
 night daytime work

Frequency of attacks _____

Last attack _____

Bronchitis

Worst season _____

Insect Allergy

When stung or bitten _____

Insect _____

Reaction(s) _____

Treatment _____

Latex Allergy

- Occupation related
- Contact dermatitis
- Hives
- Wheeze
- Other _____

- Changes in temperature
- Being around animals
What type _____
- Playing (sitting) on grass
- Emotional stress (worries, excitement, etc.)
- Other _____

Name _____ Patient No. _____

Allergy History

Previous allergy tests: Yes No If so, when? _____ By whom? _____
Were allergy injections started? _____ How long were you on them? _____
Did they help you? _____

Medication allergy or intolerance (name drug and briefly describe reactions):

Food allergy (name food and briefly describe reactions present or past)

Contact allergy (poison ivy, cosmetic, leather, metal, etc.)

Environmental History:

List other places where you have lived _____
How long have you lived in your present home _____
Location (city, farm, etc.) _____
Type of heater/air conditioner _____
Pets: Indoor _____ How long have you had it _____
Outdoor _____ How long have you had it _____
Pillow type _____ with or without plastic cover _____
Mattress type _____ with or without plastic cover _____
Blanket type _____ How old is it _____
Carpet type _____ Rug type _____
Draperies type _____ Indoor plants _____
Smoker(s) yes no in home in workplace Stuffed toys in bedroom _____

Occupational Habits and Hobbies:

What type of work _____
Do you smoke _____ How long _____ How many a day _____
Did you smoke in the past _____ How long _____ When did you stop _____
Do you drink alcohol _____ How often _____
Do you use non-medicinal (recreation) drugs _____

Past Medical History: (List previous illnesses and hospitalizations, surgeries and Emergency Room visits)

Family History: (Mark with if present)

Illness	Father	Mother	Brother	Sister	Children	Other
Asthma	_____	_____	_____	_____	_____	_____
Hay fever	_____	_____	_____	_____	_____	_____
Sinus problems	_____	_____	_____	_____	_____	_____
Hives or swelling	_____	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____	_____
Drug allergy	_____	_____	_____	_____	_____	_____
Sinus headaches	_____	_____	_____	_____	_____	_____
Migraine headaches	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Rheumatic/autoimmune	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Immunodeficiency	_____	_____	_____	_____	_____	_____

Name _____ Patient No. _____

Review of Systems

Please check (✓) all items that apply and explain briefly.

General health: good bad _____

Constitutional (general symptoms): fever weight loss weight gain night sweats weakness.
 fatigue NONE other _____

Eyes: poor vision, cataracts, glaucoma, glasses, contacts (type _____)
 NONE other _____

Ear, nose, throat and mouth (not noted in allergy history):
 pain, drainage, hearing loss vertigo (dizziness), or tinnitus (ringing), sore mouth,
 dental problem, NONE (other than allergy) other _____

Cardiovascular (heart and blood vessels):
 high blood pressure, heart attack, palpitations (and other arrhythmias), heart murmur, phlebitis.
 NONE other _____

Respiratory (covered in allergy section)

Gastrointestinal
 peptic ulcer, reflux, hepatitis, frequent vomiting, abdominal pain,
 frequent diarrhea, loss of appetite, chronic constipation, bleeding.
 NONE other _____

Genitourinary: frequent urination, dysuria (pain), hematuria, nocturia (frequent night time urination),
 recurrent infection, sexual dysfunction, kidney stones, menstrual problems, prostate
problems. NONE other _____

Musculoskeletal: joint pain, muscle pain, weakness.
 NONE other _____

Skin (covered in allergy section)

Neurological: fainting, seizures, paralysis, headaches (other than sinus).
 NONE other _____

Psychiatric: depression, anxiety, insomnia, abnormal fears, mental "breakdown".
 NONE other _____

Endocrine: thyroid dysfunction, diabetes, adrenal dysfunction,
 NONE other _____

Hematologic/Lymphatic: anemia, bleeding problem, bloodborne infection; Hepatitis B/HIV.
 NONE other _____

Cancer type: _____
 NONE

Allergy/Immunology (see allergy other section) immunodeficiency _____