

## New Patient History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

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Reason for today's visit: \_\_\_\_\_

Current Medications (dose & frequency):

Medication Allergies/Sensitivities (list reaction):

Food Allergies/Sensitivities (list reaction):

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**Symptoms-***circle all that apply*

**Ear, Nose, Throat:** runny nose, sneezing, nasal congestion, post nasal drip, sore throat, sinus pressure/pain, throat swelling, ear aches

**Eyes:** itchy, watery, dry, red, swollen, drainage, dark circles, pain

**Respiratory:** cough, shortness of breath, wheezing, chest tightness

**Skin symptoms:** hives, itching, rash, dryness, eczema

**Stomach:** upset stomach, reflux, nausea, vomiting, diarrhea, constipation, abdominal pain

**Head:** migraines, chronic headaches, vertigo, dizziness

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**Past Allergy & Asthma History-***circle all that apply*

Previous skin tests/blood tests/allergy shots?

Vaccinations up to date? Yes/No Any adverse reactions to vaccinations?

Asthma diagnosis? Yes/No made how many years ago? \_\_\_\_\_ Last chest x-ray? \_\_\_\_\_ Results?

Use of an inhaler or nebulizer? Yes/No Performed a Pulmonary Function Test? Yes/No

Stung by a bee? Yes/No Any adverse reaction? Yes/No If yes, please describe reaction:

**Medical History:**

Emergency Room Visits (*date and reason*):

Days of school or work missed per year:

**History of** (*circle all that apply*):

<b>Cancer</b>	Breast, Brain, Lung, Pancreatic, Ovarian, Prostate, Stomach, Liver, Skin, Cervical, Esophageal, Other:
<b>Cardiac</b>	Stroke, Hypertension, Palpitations, Murmur, Pacemaker
<b>Eyes</b>	Glasses, Contact lenses, Glaucoma, Blindness, Cataracts, Eye Disease
<b>Ears</b>	Hearing aids, Hearing loss, Chronic ear infections
<b>Nose</b>	Nasal polyps, Nosebleeds, Allergic rhinitis, Chronic sinusitis
<b>Skin</b>	Rash, Eczema, Acne, Hair loss, Nail disorders
<b>Musculoskeletal</b>	Arthritis, Osteoporosis, Chronic back pain
<b>Endocrine</b>	Diabetes, Thyroid condition, Autoimmune disorder, Kidney disease, Renal disease, Addison's disease, Scleroderma, Lupus
<b>Gastrointestinal</b>	Reflux, Esophagitis, Hernia, Ulcer, Polyps, Gallbladder, Crohn's Disease, Irritable Bowel Syndrome
<b>Urinary/Reproductive</b>	Breast Disease, Prostate Disease, Childbirth history
<b>Respiratory</b>	Asthma, COPD, Chronic bronchitis, Tuberculosis, Pneumonia, Emphysema, Sleep Apnea- on CPAP?
<b>Neurological</b>	Epilepsy, Seizures, Chronic headaches, Migraines, Memory loss, Stroke
<b>Psych/Social</b>	Depression, Suicide Attempt, Anxiety, Bipolar, OCD, Insomnia

**Surgical History** (list date & procedure):

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**Family History** (check all that apply):

	Asthma	Allergies	Immune Disorder	Other (list)
Father				
Mother				
Brother				
Sister				
Paternal GF				
Paternal GM				
Maternal GF				
Maternal GM				

**Social History:**

Occupation: \_\_\_\_\_ Where Employed: \_\_\_\_\_

Hobbies: \_\_\_\_\_ Number of children: \_\_\_\_\_

**Marital Status:** Single, Married, Divorced, Separated, Widowed, Other

**Primary Residence:** One home; 2 or more homes

**Tobacco Use:** Yes/No How much for how long? \_\_\_\_\_ **Tobacco Exposure:** Yes/No

**Alcohol Use:** Yes/No **Drug Dependency:** Yes/No

Pets	Number	Age	How long owned	Kept where	Bathed?	Bedroom Access?	Symptoms
Cat							
Dog							
Bird							
Rabbit							
Hamster							
Guinea Pig							
Reptile							
Other							

**Environmental History:**

**Type of Home:** Single Family, Townhouse, Mobile Home, Apartment, Other

Structure: Wood Frame, Brick. Age: \_\_\_\_\_ Length of Residency: \_\_\_\_\_

Heat/Cooling System: Forced Hot Air, Central Air, Window Air Conditioners, Radiators

Foundation: Basement, Crawl Space, Slab Dehumidifier: Yes/No

Patient's Bedroom: Carpet, Hardwood, Tile, Curtains

Bedding: Feather Pillows, Foam Pillows, Standard Bed, Water Bed. Hypoallergenic Bedding: Yes/No

Plants: Number and location of plants \_\_\_\_\_

Laundry: Location of laundry room \_\_\_\_\_ Outdoor clothes line: Yes/No

**Comments:**