

**PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PREFERRED NAME/PRONOUNS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAY’S DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Primary Care Provider (Name/Clinic):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by (Name/Clinic):**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Can we send a letter back to your primary/referring provider(s)?** ☐ **YES** ☐ **NO**

**How did you hear about our practice?**

☐ Doctor/healthcare provider ☐ Recommended by family member/friend ☐ Insurance search

☐ Google/online search ☐ Advertisement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Drive-by sighting

☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your primary goals for this visit/questions you have for your doctor?**

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE CHECK THE SYMPTOMS YOU ARE CURRENTLY/VERY RECENTLY EXPERIENCING:**

**GENERAL: EYES: EARS/NOSE/SINUSES/THROAT:**

☐ Fatigue ☐ Itchy ☐ Stuffy nose ☐ Poor sense of smell

☐ Fever ☐ Watery ☐ Runny nose ☐ Nosebleeds

☐ Difficulty sleeping ☐ Red ☐ Sneezing ☐ Ear pain/fullness

☐ Anxiety ☐ Puffy ☐ Itchy nose ☐ Snoring

☐ Depression ☐ Vision changes ☐ Post-nasal drainage ☐ Sore throat

☐ Facial pressure ☐ Itchy throat

**LUNGS: HEART/BLOOD VESSELS: GI TRACT: SKIN:**

☐ Chest tightness ☐ High blood pressure ☐ Difficulty swallowing ☐ Eczema

☐ Cough ☐ Irregular heartbeat ☐ Heartburn ☐ Hives

☐ Shortness of breath ☐ Swelling in hands/feet ☐ Itching

☐ Sputum/phlegm ☐ Swelling

☐ Wheezing

**LOCAL PHARMACY: MAIL-ORDER PHARMACY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cross-streets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**PAST MEDICAL HISTORY:**

Check all that apply:

☐ Seasonal allergies  ☐ Pet allergies ☐ Asthma/coughing/wheezing

☐ Spring ☐ Dogs ☐ With illness

☐ Summer ☐ Cats ☐ With exercise

☐ Fall ☐ Rabbits ☐ With allergy symptoms

☐ Winter ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_ ☐ With cold/humid air

☐ All year symptoms ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Around smoke/irritants

☐ Hives ☐ Eczema

☐ With heat exposure ☐ In the winter/cold exposure

☐ With cold exposure ☐ In the summer/heat exposure

☐ With pressure ☐ With exposure to chlorine

☐ With friction/vibration ☐ Due to foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Due to medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Due to environmental allergies\_\_\_\_\_\_\_\_\_\_\_\_

☐ Due to foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Food allergies -> list culprit foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Recurrent infections -> list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other conditions:**

☐ Heartburn/reflux ☐ COPD ☐ Thyroid disease ☐ Latex allergy

☐ Heart disease ☐ Kidney disease ☐ Liver disease ☐ Cancer

☐ Diabetes ☐ Anxiety/depression ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you previously been tested for allergies?** ☐ YES; when/where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ NO

**Did you previously take allergy shots?** ☐ YES; how long/helpful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ NO

**Do you have a penicillin allergy?** ☐ YES; have you had testing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ NO

**Prior severe reaction to a bee/wasp/hornet sting?** ☐ YES - have you had testing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ NO

**PAST SURGICAL HISTORY:**

☐ Tonsillectomy (year\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_)

☐ Adenoidectomy (year\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_)

☐ Sinus surgery (year\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_)

☐ Ear tubes (year\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_)

**PRIOR HOSPITALIZATIONS:**

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_)

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year\_\_\_\_\_)

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**MEDICATIONS:**

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATION ALLERGIES:**

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**FAMILY MEDICAL HISTORY:**

☐ Environmental allergies ☐ Asthma ☐ Eczema ☐ COPD

☐ Immune deficiency/severe infections ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

☐ Single ☐ Married ☐ Domestic partnership ☐ Widowed ☐ Divorced/separated ☐ Other

☐ No pet exposures ☐ Current pet exposures (type, location) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Never used tobacco/vaping ☐ Prior use of tobacco/vaping ☐ Exposed to tobacco/vaping 2nd hand

☐ Current use of tobacco/vaping ☐ I am interested in quitting tobacco/vaping

☐ Travel outside the US in the past 6 months (list countries) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Primary language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Race/ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Country of origin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORKPLACE HISTORY:**

**Are you currently employed?** ☐ YES ☐ NO (☐ Full-time ☐ Part-time)

* If yes, employer/job description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms worse at work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If no, are you: ☐ SAHM/D ☐ Retired ☐ Disabled ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently a student?** ☐ YES ☐ NO

* If yes, what grade/school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms worse at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENVIRONMENTAL HISTORY:**

**Describe your home:** ☐ House ☐ Condo ☐ Townhome ☐ Apartment ☐ Other

☐ City ☐ Suburbs ☐ Rural area/farmstead ☐ Other

**What year was your home built? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your HVAC:**  ☐ Forced air heat ☐ Gas heat ☐ Electric heat ☐ Hot water heat

☐ Wood-burning stove ☐ Kerosene heat ☐ Space heater ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Central A/C ☐ Window A/C unit(s) ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ No mold/water damage in home ☐ Damp basement at times ☐ Current mold/water - needs remediation