

McGOVERN ALLERGY AND ASTHMA CLINIC, P.A.

PATIENT INFORMATION SHEET

PLEASE PRINT

PATIENT NO. _____

DATE _____

DR. MR. MRS. MISS MS.

PATIENT'S NAME				LAST	FIRST	MIDDLE	PATIENT'S HOME PH #	BUSINESS PH #
HOME ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE #		BIRTHDATE
MAILING ADDRESS		STREET	CITY	STATE	ZIP	AGE	PATIENT'S SS # - -	
RACE	<input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> HAWAIIAN OPI <input type="checkbox"/> AMERICAN INDIAN AK NAT <input type="checkbox"/> WHITE <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> OTHER RACE <input type="checkbox"/> DECLINED							PATIENT'S GENDER
								<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ETHNICITY <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NON HISPANIC/LATINO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED							MARITAL STATUS	
							<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW/WIDOWER	
LANGUAGE PREFERENCE								
<input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> GERMAN <input type="checkbox"/> ITALIAN <input type="checkbox"/> JAPANESE <input type="checkbox"/> PORTUGUESE <input type="checkbox"/> RUSSIAN <input type="checkbox"/> SPANISH <input type="checkbox"/> ARABIC <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER								
OCCUPATION			PLACE OF EMPLOYMENT			E-MAIL		
EMPLOYER'S ADDRESS			STREET	CITY	STATE	ZIP	CONTACT: HOW DO YOU PREFER TO BE CONTACTED:	
						<input type="checkbox"/> POSTAL MAIL <input type="checkbox"/> E-MAIL <input type="checkbox"/> HOME PHONE <input type="checkbox"/> CELL PHONE		
SPOUSE'S FULL NAME			OCCUPATION		PLACE OF EMPLOYMENT		Cell Phone No.	
							() -	
ADDRESS OF SPOUSE'S EMPLOYER				CITY	STATE	ZIP	Business Phone No.	
							() -	
CHIEF PROBLEM								
REFERRED BY								
NAME		ADDRESS			CITY	STATE	ZIP	
PATIENT'S PRIMARY CARE PHYSICIAN								
ADDRESS		CITY			STATE	ZIP	PHONE #	
PHARMACY								
NAME		LOCATION/ADDRESS				PHONE #		
EMERGENCY CONTACT								
NOT LIVING WITH YOU _____			PHONE NO. _____			RELATIONSHIP _____		

INSURANCE COMPANY		INSURED'S NAME		DATE OF BIRTH
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 / GUARDIAN *		DATE OF BIRTH	PLACE OF EMPLOYMENT/OCCUPATION	Business Phone No.
HOME ADDRESS			ADDRESS	() -
				Home / Cell No.
				() -
MOTHER'S FULL NAME / GUARDIAN *		DATE OF BIRTH	PLACE OF EMPLOYMENT/OCCUPATION	Business Phone No.
HOME ADDRESS			ADDRESS	() -
				Home / Cell No.
				() -

* LEGAL GUARDIAN, FOSTER PARENT, POWER OF ATTORNEY, INSTITUTIONAL REPRESENTATIVE

X

SIGNATURE

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) _____

Headache Symptoms

First noticed _____

- sharp pressure
- dull 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 _____

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

- | | |
|--|---|
| <input type="checkbox"/> Weather change | <input type="checkbox"/> Perfume or cosmetics |
| <input type="checkbox"/> Rainy days | <input type="checkbox"/> House cleaning, moving |
| <input type="checkbox"/> Foggy days | <input type="checkbox"/> House dust |
| <input type="checkbox"/> Fumes | <input type="checkbox"/> Mowing the lawn |
| (Insecticides, chemicals, tobacco smoke) | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Physical exertion | <input type="checkbox"/> Change of locale |
| <input type="checkbox"/> Musty odors | <input type="checkbox"/> Newsprint |

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

Medications:

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

List other current (non-allergy medications)

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 _____