



**NEW PATIENT FORM**  
 (Please complete *prior* to your visit)

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**NAME:** \_\_\_\_\_

Appointment Date/Time: \_\_\_\_\_

Address:

Medical Insurance:

Number:

Name of Subscriber:

Telephone Number:

Cell phone Number:

Alternate Number:

Parent/Spouse:

Pharmacy Name/Number:

SSN:

Primary Care Provider:

DOB:

Age:

Referred By:

**Reason for Visit:**

**Do you have any of the following?**

**Please circle**

**Details**

|                              | <b>Please circle</b> | <b>Details</b>                  |
|------------------------------|----------------------|---------------------------------|
| Asthma                       | Yes / No             | Date of Diagnosis:              |
| Environmental allergy        | Yes / No             | Pollen Mold Dust Animals Other: |
| Food allergy                 | Yes / No             | Foods:                          |
| Venom (insect sting) allergy | Yes / No             | Date of Reaction:               |
| Medication allergy           | Yes / No             | List medication/reaction:       |
| Hives                        | Yes / No             | Date of onset:                  |
| Eczema                       | Yes / No             | Body parts involved:            |
| Nasal polyps                 | Yes / No             |                                 |
| Sinus infections             | Yes / No             | How many per year?              |
| Pneumonia                    | Yes / No             | How many per year?              |
| Latex allergy                | Yes / No             |                                 |
| Contact dermatitis           | Yes / No             | Causes identified:              |

PATIENT NAME: \_\_\_\_\_

**MEDICAL HISTORY - Do you have any of the following? Please circle:**

High blood pressure      High cholesterol      Diabetes      Arthritis      Heartburn/Reflux  
Kidney problems      Thyroid problems      Cancer (what type?)      Other:

**SURGICAL HISTORY - Please list all surgeries and dates:**

**SOCIAL HISTORY:**

Where do you live? House / Apartment / Condo / Townhome  
How long have you lived there?      How old is the building?  
Flooring in home: carpet / hardwood / area rug  
Do you have a basement? Yes / No      If yes, is it: Wet / Dry      Any visible mold? Yes / No  
Bedroom: Type of pillows:      Type of mattress:      Allergy covers?: Yes / No  
Bedroom Flooring: carpet / hardwood / area rug  
Heating: Forced hot air / Forced hot water / Electric / Wood stove / Fireplace  
Pets:  
Occupation:  
Do you smoke? Yes / No      If so, how much and for how long?  
Exposure to second-hand smoke? Yes / No  
Do you drink alcohol? Yes / No      If so, how much and how often?

**FAMILY HISTORY - Does anyone in your family have the following? Please check:**

|                         | Father | Mother | Brother | Sister | Son | Daughter | Other |
|-------------------------|--------|--------|---------|--------|-----|----------|-------|
| Asthma                  |        |        |         |        |     |          |       |
| Environmental allergies |        |        |         |        |     |          |       |
| Food allergies          |        |        |         |        |     |          |       |
| Medication allergies    |        |        |         |        |     |          |       |
| Sinusitis               |        |        |         |        |     |          |       |
| COPD/Emphysema          |        |        |         |        |     |          |       |

**MEDICATIONS - List all current medications (prescriptions, over-the-counter, supplements):**