Wexford Allergy, Asthma & Immunology, LLC
100 Bradford Road, Suite 410, Wexford, PA 15090
Phone (724)719-2441 / Fax (724)719-2451
www.wexfordallergy.com

New Patient Registration and Medical History

Name _____ Today's date _____

Address _____ City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Email _____

Birth date _____ Sex M/F Marital status _____ Social security # _____

Occupation & employer/school _____ Race/Ethnicity _____

Referring physician _____ Primary care physician _____

Preferred pharmacy name & phone # _____ Mail order pharmacy _____

What is the reason for your visit today?

If you have been given a diagnosis by another physician, please specify it here, as well as the diagnosis code if known.

PAYMENT AND INSURANCE INFORMATION

Please note that we will need to copy your photo ID and insurance card.

Primary Insurance _____ Member ID# _____

Group name _____ Group/Plan # _____

Policy holder/Subscriber name _____ Relationship to patient _____

Policy holder/Subscriber birth date _____ Phone number _____

Policy holder/Subscriber address _____

Do you have separate pharmacy coverage? Yes / No If yes, please provide the ID # _____

Secondary Insurance (if applicable) _____ Member ID# _____

Group name _____ Group/Plan # _____

Policy holder/Subscriber name _____ Relationship to patient _____ Birth date _____

Financially responsible party

If the patient is a minor, to whom should bills be sent? Name _____

Relationship to patient _____ Date of birth _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

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Patient name _____

ALLERGY AND ASTHMA HISTORY

Date of birth _____

	Yes	No	If yes, please answer the questions below:
Has the patient ever been diagnosed with asthma?			**At what age?** **Any hospitalizations for asthma? When?** **Any ER visits for asthma? When?** **Any oral steroids (prednisone) for asthma? When?**
Has the patient ever had allergy testing before?			**When?** **By whom?** **Ever on allergy shots?**
Has the patient ever been diagnosed with eczema?			**Evaluated by a dermatologist?**
Has the patient had adverse reactions to foods?			**Please explain.**
Has the patient had adverse reactions to medications?			**Please explain.**
Has the patient had adverse reactions to bee stings?			**Please explain.**
Has the patient had adverse reactions to latex?			**Please explain.**

Patient name _____

PAST MEDICAL HISTORY

Date of birth _____

Is the patient pregnant? Yes No (Please circle your response)

Please indicate if the patient has, or is being treated for, any of the following:

	Yes	No		Yes	No		Yes	No
Cataracts			**Thyroid disease**			**Sleep apnea**		
Glaucoma			**Lupus**			**GERD (heartburn)**		
Osteoporosis			**Rheumatoid arthritis**			**Headache/Migraine**		
Anemia			**Celiac disease**			**Nasal polyps**		
Diabetes			**Psoriasis**			**Sinus infections**		
Heart disease			**Anxiety**			**Ear infections**		
High blood pressure			**Depression**			**Pneumonia**		
High cholesterol			**Cancer (specify type)**			**COPD (emphysema)**		

Does the patient have **any other medical problems**? Please specify.

HOSPITALIZATION HISTORY

Please list **all hospitalizations** the patient has had, with the **year** and the **reason:**

SURGICAL HISTORY

Please indicate if the patient has had **any of the following** procedures, and specify the **year**:

	Yes	No	When		Yes	No	When
Tonsillectomy				**Sinus surgery**			
Adenoidectomy				**Nasal surgery**			
Ear tubes				**Nasal polyp removal**			

Has the patient had **any other surgery**? If yes, please **specify the procedure and year** it was performed.

Patient name _____

FAMILY HISTORY

Date of birth _____

Have any of the patient's **blood relatives** been diagnosed with any of these conditions? If yes, please specify who:

	Yes	No	Who?		Yes	No	Who?
Asthma				**Cataracts**			
Allergic rhinitis/hay fever				**Glaucoma**			
Eczema				**Thyroid disease**			
Food allergies				**Lupus**			
Celiac disease				**Rheumatoid arthritis**			
Urticaria (hives)				**Cancer (type?)**			
Angioedema (swelling)				**Diabetes**			
COPD/Emphysema				**Hypertension**			
Osteoporosis				**High cholesterol**			

MEDICATIONS

Please list the patient's current medications and doses.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

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ENVIRONMENTAL HISTORY

	Yes	No	If yes, please answer:
Are there any pets in the patient's home, or is there any other exposure to animals?			**What kind, and how many?**
Has the patient ever smoked?			**How much, and for how long?** **Does the patient want to quit?**
Does anyone smoke around the patient?			
Does the patient go to school or daycare (children)?			
What is the patient's occupation?			
Is there anything the patient is exposed to that you believe triggers symptoms? **Any season when they get worse?**			**Please explain.**

IMMUNIZATIONS

If the patient is age 18 years or under, is he/she **up to date on all childhood vaccines?** Yes No

When was the patient's **last flu shot?** Please give the date. _____

Has the patient **ever had a pneumonia vaccine?** Yes No

If yes, which one, and when? Pneumovax date _____ Prevnar date _____

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REVIEW OF SYSTEMS – Is the patient **currently** experiencing any of the following symptoms?

GENERAL ○ Fever ○ Chills ○ Fatigue	**MOUTH/THROAT** ○ Itchy throat ○ Sore throat ○ Frequent throat clearing ○ Hoarseness	**MUSCULOSKELETAL** ○ Muscle pain ○ Joint pain ○ Joint stiffness ○ Joint swelling ○ Joint redness/warmth
EYES ○ Red ○ Watery ○ Itchy ○ Swelling	**NECK** ○ Lumps	**SKIN** ○ Rash ○ Hives ○ Itching ○ Flaking/peeling ○ Swelling ○ Redness/flushing
EARS ○ Pain ○ Fullness/popping ○ Itching	**RESPIRATORY** ○ Cough ○ Wheeze ○ Difficulty breathing ○ Chest tightness ○ Trouble with exercise	**NEUROLOGIC** ○ Headache ○ Dizziness/vertigo
NOSE ○ Stuffy/congested ○ Itchy ○ Runny ○ Sneezing ○ Loss of sense of smell ○ Post-nasal drip ○ Sinus pressure ○ Nosebleeds	**GASTROINTESTINAL** ○ Stomach pain ○ Heartburn ○ Nausea ○ Vomiting ○ Diarrhea ○ Constipation	**PSYCHIATRIC** ○ Stressors ○ Sleep disturbance