

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 _____

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 _____

ALLERGY AND ASTHMA HISTORY

Patient name _____

	Yes	No	If yes, please answer the questions below:
Have you ever been diagnosed with asthma?			<p>At what age?</p> <p>Any hospitalizations for asthma? When?</p> <p>Any ER visits for asthma? When?</p> <p>Any oral steroids (prednisone) for asthma? When?</p>
Have you ever had allergy testing before?			<p>When?</p> <p>By whom?</p> <p>Were you on allergy shots?</p>
Have you ever been diagnosed with eczema?			Do you see a dermatologist?
Have you had adverse reactions to foods?			Please explain.
Have you had adverse reactions to medications?			Please explain.
Have you had adverse reactions to bee stings?			Please explain.
Have you had adverse reactions to latex?			Please explain.

PAST MEDICAL HISTORY

Please indicate if you have, or are 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)		

Do you have **any other medical problems**? Please specify.

HOSPITALIZATION HISTORY

Please list **all hospitalizations** you have had, with the **year** and the **reason**:

SURGICAL HISTORY

Please indicate if you have 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			

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

FAMILY HISTORY

Has anyone in your family (**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 your current medications and doses.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

ENVIRONMENTAL HISTORY

	Yes	No	If yes, please answer:
Do you have pets at home, or are you around animals when away from home?			What kind, and how many?
Have you ever smoked?			How much, and for how long? Do you want to quit?
Does anyone smoke around you?			
Do you go to school or daycare (children)?			
What is your occupation (adults)?			
Is there anything you are exposed to that you believe triggers your symptoms? Any season when they get worse?			Please explain.

IMMUNIZATIONS

	Yes	No
Children: Are you up to date on all of your childhood vaccines?		
Adults: 1. Do you get an annual flu shot? 2. Have you ever received Pneumovax (pneumonia vaccine)?		

REVIEW OF SYSTEMS – Are you **currently** experiencing any of the following symptoms?

GENERAL <ul style="list-style-type: none"> <input type="radio"/> Fever <input type="radio"/> Chills <input type="radio"/> Fatigue 	MOUTH/THROAT <ul style="list-style-type: none"> <input type="radio"/> Itchy throat <input type="radio"/> Sore throat <input type="radio"/> Frequent throat clearing <input type="radio"/> Hoarseness 	MUSCULOSKELETAL <ul style="list-style-type: none"> <input type="radio"/> Muscle pain <input type="radio"/> Joint pain <input type="radio"/> Joint stiffness <input type="radio"/> Joint swelling <input type="radio"/> Joint redness/warmth
EYES <ul style="list-style-type: none"> <input type="radio"/> Red <input type="radio"/> Watery <input type="radio"/> Itchy <input type="radio"/> Swelling 	NECK <ul style="list-style-type: none"> <input type="radio"/> Lumps 	SKIN <ul style="list-style-type: none"> <input type="radio"/> Rash <input type="radio"/> Hives <input type="radio"/> Itching <input type="radio"/> Flaking/peeling <input type="radio"/> Swelling <input type="radio"/> Redness/flushing
EARS <ul style="list-style-type: none"> <input type="radio"/> Pain <input type="radio"/> Fullness/popping <input type="radio"/> Itching 	RESPIRATORY <ul style="list-style-type: none"> <input type="radio"/> Cough <input type="radio"/> Wheeze <input type="radio"/> Difficulty breathing <input type="radio"/> Chest tightness <input type="radio"/> Trouble with exercise 	NEUROLOGIC <ul style="list-style-type: none"> <input type="radio"/> Headache <input type="radio"/> Dizziness/vertigo
NOSE <ul style="list-style-type: none"> <input type="radio"/> Stuffy/congested <input type="radio"/> Itchy <input type="radio"/> Runny <input type="radio"/> Sneezing <input type="radio"/> Loss of sense of smell <input type="radio"/> Post-nasal drip <input type="radio"/> Sinus pressure <input type="radio"/> Nosebleeds 	GASTROINTESTINAL <ul style="list-style-type: none"> <input type="radio"/> Stomach pain <input type="radio"/> Heartburn <input type="radio"/> Nausea <input type="radio"/> Vomiting <input type="radio"/> Diarrhea <input type="radio"/> Constipation 	PSYCHIATRIC <ul style="list-style-type: none"> <input type="radio"/> Stressors <input type="radio"/> Sleep disturbance