FREEDOM ALLERGY
ALLERGY SINUS AND COUGH CENTER

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New Patient Intake Form

Name:_____ Date:_____ Age:_____ Sex: M___ F___

Primary Care Provider: _____ Primary Care Provider phone #: _____

Primary Care Provider Address: _____

Please describe in your own words your main reason(s) for seeing us today:

How long has this (above problem) been going on? _____

Check all boxes below that apply to your symptoms, and circle whether this is a problem now or in the past. Circle both if it is both a past and present problem.

[ ] Eye itching (past or present)
[ ] Eye watering (past or present)
[ ] Eye redness (past or present)
[ ] Eye swelling/puffy eyes (past or present)
[ ] Need to rub eyes/nose repeatedly (past or present)
[ ] Runny nose/nasal drainage/need to blow nose repeatedly (past or present)
[ ] Nasal congestion/stuffy nose (past or present)
[ ] Sneezing (past or present)
[ ] Headache (past or present)
[ ] Hoarseness (past or present)
[ ] Constant clearing of throat (past or present)
[ ] Nasal polyps (past or present)
[ ] Hearing Loss (past or present)
[ ] Impaired smell/taste (past or present)
[ ] Snoring (past or present)
[ ] Fatigue
[ ] Dry cough (past or present)
[ ] Cough + sputum production (past or present)
[ ] Chest tightness or congestion (past or present)
[ ] Wheezing (past or present)
[ ] Shortness of breath (past or present)
[ ] Chest pain (past or present)
[ ] Hives/whelts (past or present)
[ ] Giant swelling of face, eyelids, mouth, lips, tongue, or throat (past or present)
[ ] Skin reaction to poison ivy/oak/sumac, metals, chemicals, or cosmetics (past or present)
[ ] Eczema (past or present)

Check any items below that worsen your symptoms. Please provide more detail as necessary.

[ ] Spring (March/April/May)
[ ] Dampness
[ ] Sleep
[ ] Summer (June/July/August)
[ ] Cold
[ ] Exercise
[ ] Fall/autumn (Sept/Oct/Nov)
[ ] Air conditioning
[ ] Emotional upset
[ ] Winter (Dec/Jan/Feb)
[ ] Cosmetics/perfumes
[ ] Being at work
[ ] Being outdoors
[ ] Smog
[ ] Foods _____
[ ] Being indoors
[ ] Weather changes
[ ] Other _____
[ ] Dogs, cats or birds
[ ] Irritant fumes/aerosols/sprays
_____
[ ] Other animals _____
[ ] Tobacco smoke
_____

How many "colds," "flulike illnesses," upper respiratory tract infections (sinus/ear/throat infections), or bronchial infections have you had in the past year? _____

How many of the above did you have per year in the past five years? #_____/year

What percentage of these infections required antibiotics (please circle)? (0, 10, 25, 50, 75, 90, 100%)

Which antibiotics have worked the best for you in the past? _____

Do you have history of any of the following in yourself or a relative? (Circle "self" "mom," "dad," or "other" family member).

Hay fever/"allergies"	Y__ N__ self mom dad other:_____	Hypertension	Y__ N__ self mom dad other: ____
Asthma	Y__ N__ self mom dad other:_____	Heart disease	Y__ N__ self mom dad other: ____
Hives	Y__ N__ self mom dad other:_____	Diabetes	Y__ N__ self mom dad other: ____
Eczema	Y__ N__ self mom dad other:_____	Cancer	Y__ N__ self mom dad other: ____
Insect sting allergy	Y__ N__ self mom dad other:_____	Anemia	Y__ N__ self mom dad other: ____
Chronic sinus issues	Y__ N__ self mom dad other:_____	High cholesterol	Y__ N__ self mom dad other: ____
Chronic bronchitis	Y__ N__ self mom dad other:_____	Arthritis	Y__ N__ self mom dad other: ____
Cystic fibrosis	Y__ N__ self mom dad other:_____	Thyroid disease	Y__ N__ self mom dad other: ____

(Review of Systems): Are you currently having any problems with any of the following?

Y___ N___ Weight changes, loss of appetite, fever, chills, night sweats? Explain: _____
Y___ N___ Changes in skin/hair/nails, rash? Explain: _____
Y___ N___ Joint pain/swelling, weakness, stiffness, muscle aches? Explain: _____
Y___ N___ Vision loss, double vision, glaucoma, cataracts? Explain: _____
Y___ N___ Sinus problems, hearing loss, nasal polyps, ringing in ears? Explain: _____
Y___ N___ Headaches, migraines, seizures, memory loss, numbness? Explain: _____
Y___ N___ Swollen glands, lumps in the neck? Explain: _____
Y___ N___ HIV/AIDS, tuberculosis, other chronic infections? Explain: _____
Y___ N___ Blood pressure, heart disease, chest pain, high cholesterol, swelling of legs, strokes? Explain: _____
Y___ N___ Wheezing, asthma, shortness of breath, chest tightness? Explain: _____
Y___ N___ Diabetes, thyroid deficiency, thyroid excess, autoimmune disease? Explain: _____
Y___ N___ Trouble swallowing, nausea, vomiting, diarrhea, heartburn? Explain: _____
Y___ N___ Hepatitis and/or liver disease? Explain: _____
Y___ N___ Burning or blood in urine, kidney stones, prostate problem? Explain: _____
Y___ N___ Blood clots, bleeding disorders, easy bruising, bloody/dark stools, anemia? Explain: _____
Y___ N___ Anxiety, depression, mental illness, hallucinations, drug addiction? Explain: _____
Y___ N___ (Female patients only) Pregnant, irregular periods, discharge? Explain: _____

List your current medications (including non-prescription medications & supplements):

_____
_____
_____

List all allergies to medications and foods. _____
How long have you lived in Georgia? _____ Where did you live before? _____
Do you live in an apartment, house, mobile home, or other? _____
Who lives with you at home? _____
How old is your home? _____ How long have you lived there? _____

Do you have a HEPA or other special air filter at home? _____
Do you have carpet at home? _____ Which rooms are carpeted? _____
Do you have any household pets? Yes____ No____ Kind of pet: # at home
Do you smoke? Yes____ No____ If yes, how many packs do you smoke a day (on average)? _____
For how many total years have you smoked? _____
If you were a smoker, how many years did you smoke?_____ When did you quit? _____
Are there smokers in the family? Yes__ No__ Do they smoke at home? Yes__ No__
Occupation: _____ Where do you work? _____
Hobbies/Activities:_____ Where to you perform these?_____

Have you had previous allergy testing/evaluation? Yes__ No__
If yes, please describe:

Date	Doctor Name and City	Result(s)

Have you had allergy shots/injections? Yes____ No____ For how long? _____
Did the injections help you? Yes____ No____
Did you have any reactions to the shots? Yes____ No____
If yes, please describe the reaction:_____