FREEDOM ALLERGY

ALLERGY SINUS AND COUGH CENTER

115 Genevieve Court, Peachtree City, GA 30269
1255 Johnson Ferry Road, Suite 2A, Marietta, GA 30068

Patient Intake Form

Today's Date:_____

Patient Name:_____ Patient Date of Birth:_____

Reason for appointment

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

_____

The main problems I have are:

	Eyes		**Ears**		**Nose**
☐	Eye itching	☐	Ear itching	☐	Nose itching (need to rub repeatedly)
☐	Eye redness	☐	Ear ache/pain	☐	Sneezing
☐	Eye watering	☐	Ear ringing	☐	Runny nose / Nasal drainage
☐	Eye swelling/puffy eyes	☐	Ear plugging	☐	Yellow/Green nasal drainage
☐	Eye dryness	☐	Ear discharge	☐	Stuffy nose / Nasal congestion
☐	Need to rub eyes repeatedly	☐	Recurrent ear infections	☐	Nasal polyps
☐	Sensitive to light	☐	Hearing loss	☐	Mouth breather
		☐	Headache	☐	Snoring
				☐	Impaired smell/taste
				☐	Nose bleeds
				☐	Nasal / Sinus Procedures?

	Throat		**Chest**		**Skin**
☐	Constant clearing of throat	☐	Chest tightness or congestion	☐	Hives/whelts
☐	Dry cough	☐	Wheezing	☐	Eczema (red, scaly, itchy skin)
☐	Cough + sputum production	☐	Shortness of breath	☐	Giant swelling of face, eyelids, mouth, lips, tongue, or throat
☐	Throat itchiness	☐	Chest pain	☐	Skin reaction to poison ivy/oak/sumac, metals, chemicals, or cosmetics
☐	Sore throat	☐	Heartburn	☐	Recurrent skin infections
☐	Post nasal drip	☐	Asthma	☐	Rash
☐	Hoarseness			☐	Sensitive to rubber or latex products
☐	Throat swelling				

These symptoms occur or are made worse by:

☐	Spring (March/April/May)	☐	Dampness	☐	Sleep
☐	Summer (June/July/August)	☐	Cold	☐	Emotional upset
☐	Fall/autumn (Sept/Oct/Nov)	☐	Smog	☐	Animals (dogs, cats, birds, etc)
☐	Winter (Dec/Jan/Feb)	☐	Air Conditioning	☐	Irritant fumes/aerosols/sprays
☐	Sudden weather changes			☐	Cosmetics
		☐	Exercise	☐	Odors or scents
☐	Being outdoors	☐	Yardwork		
☐	Being indoors	☐	Dusting or vacuuming	☐	Foods (specify)
☐	Being at work	☐	Tobacco smoke	☐	Other:

List your current medications (including prescription, over-the-counter, vitamins, supplements, etc):

Name	Strength/Dose/Frequency	Start Date

Allergy Medical History

Please identify food, insect, or drug causing a reaction, describe the reaction, and date of reaction:

_____

_____

_____

Have you had previous allergy testing? If yes, please describe:

	Date	Doctor Name	City, State	Skin/Blood Test?	Result(s)
1					
2					
3					

Have you had allergy shots/injections?
☐ yes ☐ no

How long did you do allergy shots?
_____ ☐ still getting allergy shots

Did the injections help you?
☐ yes ☐ no

Did you have any reactions to the shots?
☐ yes ☐ no

If yes, please describe the reaction:

_____

Infection History:

How many “colds,” “flu-like 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? _____

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

Have you had sinus surgery, tonsils/adenoids removed or ear tubes? ☐ yes ☐ no

Asthma History:

Age of onset of hay fever and/or asthma? _____

What time of day or night is the worst for your symptoms? _____

Have you ever been hospitalized for your asthma? ☐ yes ☐ no If yes, date? _____

Have you had previous testing? ☐ pulmonologist function testing ☐ chest x-ray

How often do you need to use albuterol (# times/week? #times /month?)? _____

How many times per year have you been on oral steroids? _____

Home information:

How long have you lived in the South? _____

Do you live in an:
☐ House ☐ Apartment
☐ Mobile Home ☐ Other

Does your home have a basement?
☐ yes ☐ no

History of water damage in your home?
☐ yes ☐ no

How old is your home? _____

Do you smoke, or are there smokers in the home? ☐ yes ☐ no

Kind of pet(s): _____

Are your household pets:
☐ indoor ☐ outdoor
☐ allowed in bedroom

Inside the House:

Heating: ☐ central ☐ electric
☐ gas ☐ wood fireplace

Air Conditioning:
☐ central ☐ in-window ☐ fans

Filter system (HEPA or any other air purifier/filtration system?) ☐ yes ☐ no

Flooring in Main Areas:
☐ carpet ☐ laminate / hardwood / tile

Flooring in Bedroom:
☐ carpet ☐ laminate / hardwood / tile

Allergy encasement on:
☐ mattress/boxspring ☐ pillow

Humidifier? ☐ yes ☐ no

Family History

Do you have history of any of the following in yourself or a family member?

	Self	Mom	Dad	Sibling	Other family
Hay fever/"allergies"	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Hives	☐	☐	☐	☐	
Eczema	☐	☐	☐	☐	
Insect sting allergy	☐	☐	☐	☐	
Chronic sinus issues	☐	☐	☐	☐	
Chronic bronchitis	☐	☐	☐	☐	
Cystic fibrosis	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	
Heart disease	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
High cholesterol	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Thyroid disease	☐	☐	☐	☐	
GERD	☐	☐	☐	☐	

Are you currently having any problems with any of the following?

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