



NEW PATIENT CLINICAL INFORMATION

Office Use Only	
Ins	_____
Ded	_____/_____/_____
H	____'____"
W	_____ lbs

Date

Patient First Name Patient Last Name Preferred Name

Date of Birth Age

Pharmacy Name Pharmacy Location Pharmacy Phone Number

Primary Care Provider Referring Provider

Please list any other PROVIDERS currently treating you for your problem:

Please sign and return a records release for each of the providers listed above. This is so we can ensure that we have any notes, labs or imaging results that will be needed for your visit.

Describe the REASON(S) FOR YOUR VISIT. _____

Describe your specific SYMPTOMS: _____

Please list all CURRENT MEDICATIONS. Make sure to include ALLERGY medications.

1	6
2	7
3	8
4	9
5	10

Do you have any family or friends that come here? _____

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Allergy/Sinus Testing

Have you been tested by an allergist in the past 2 years? No Yes, by Dr. _____

Results of allergy tests: No Allergy Positive to: _____

Have you been evaluated by an ENT in the past 2 years? No Yes, by Dr. _____

Have you had a sinus CT in the past 2 years? Yes No

Have you had sinus or nasal surgery performed by an ENT in the past 2 years? Yes No

Have you recently had blood work specifically to evaluate your immune system? Yes No

Have you ever had an insect sting that resulted in a severe allergic reaction? Yes No

Do any foods cause you to have hives, itching, swelling or anaphylaxis? No Yes, _____

Social History

Marital Status: Dependent Child Single Married Divorced Widowed

Student: No Yes School / Grade _____

Current or Most Recent Occupation: _____

Birthplace (City / State): _____

Indoor Pets: Cats Dogs Other Pet Exposures _____

Flooring in Bedroom: Carpet Hardwood Tile

Check the following that is in your home: Mold Mice Cockroach

Do you have a down feather blanket and/or down feather pillows on the bed? Yes No

Do you have drapes or heavy curtains on your bedroom windows? Yes No

Do you smoke/vape? Yes No

Are you exposed to secondhand smoke? Yes No

Family History

Do you have any immediate family members with the following?

Hay Fever / Nasal Allergies: No Yes, list whom _____

Asthma: No Yes, list whom _____

Food Allergy: No Yes, list whom _____

Eczema: No Yes, list whom _____

Immunodeficiency: No Yes, list whom _____

Other pertinent family history: _____

Drug Allergies

List any drugs that cause serious reactions (Other than nausea / Vomiting):

Drug Type of Reaction

Drug Type of Reaction

Drug Type of Reaction

Preventative Care

Please list the date of the most recent immunization.

Pneumovax _____ Prevnar _____ HIB _____

Up to date on childhood vaccines? Yes No