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Patient Information Sheet – To Be Filled Out By Patient or Patient's Representative

Name: _____ **Date of Birth:** _____
First M.I. Last

Reason for visit: _____ **Primary Care Provider:** _____

Do you currently have a fever or respiratory infection? ☐ YES ☐ NO

Medications (including over-the-counter medications, herbals, and supplements)

Name of Medication	Dose	How many times per day	Reason

Hospitalizations/Surgeries

Date	Hospital	Reason for admission

List other health problems:

_____

_____

Please provide the following information:
Does the patient or children in the home attend daycare? ☐YES☐ NO
Highest grade/Education level completed_____
Occupation/Job_____
Were you ever exposed to harmful chemicals, radiation, dust, or asbestos?

_____
Hobbies_____
Does anyone smoke in the home or in cars with the patient? ☐YES ☐ NO
Smoking – Current ☐YES☐ NO **In the past -** ☐YES☐ NO
If you answered yes to smoking, how many years did you smoke? ____ How many packs per day did you smoke?

____
Alcohol intake ☐YES ☐NO **How many drinks per week? ____**
"Street" drug use ☐YES ☐NO **What drugs are used?** _____

Family History (established/follow up patients – update if any changes)

Check if any apply	None	Mother	Father	Sister	Brother	Child
Allergies (hay fever)						
Asthma						
Eczema or atopic dermatitis						
Allergy to peanut or tree nuts						
Recurrent infections						
Immunodeficiency						
Recurrent hives						
Thyroid problems						
Diabetes						
Autoimmune disease (rheumatoid arthritis, lupus, etc)						

Do you have any skin problems with nickel, jewelry, or metals? ☐YES ☐NO
If yes, describe what happened: _____
Have you ever had a reaction to a stinging insect? ☐YES ☐NO
If yes, describe what happened: _____
Have you ever had a reaction to latex or problems with balloons or Band-Aids? ☐YES ☐NO
If yes, describe what happened: _____
Do you have dust mite covers on your bedding and pillows? ☐YES ☐NO
Do you have any down or feather bedding? ☐YES ☐NO
Have you ever had an allergic reaction to food or medication? _____
If yes, describe what it was/what happened: _____
Do you have any pets at home? Please list. _____

Immunizations: Date of last tetanus/diphtheria shot: _____ Date of last flu shot: _____
Date of pneumonia shot (Pneumovax) if received: _____

Please circle any symptom or condition below that you have experienced.

GENERAL HEALTH		**EARS**		**CARDIOVASCULAR**	
Weight loss	✔	Ear infections		Chest pain	
Weight gain		Ear itching		Breathing problems during exercise	
Recurrent fevers		Earache		Fast heart rate	
SKIN		**NOSE**		**GI**	
Rashes		Snoring		Vomiting	
Itchy skin		Nasal drainage		Diarrhea	
Hives		Sinus infections		Abdominal pain	
History of abscesses/infections		Bleeding			
				NEURO	
HEAD		**THROAT/MOUTH**		Seizures	
Facial swelling		Sore throat		Headaches	
Facial pain		Mouth ulcers		Dizziness	
Facial pressure		Hoarseness		Fainting	
EYES		**RESPIRATORY**		**PSYCHIATRIC**	
Eye swelling		Cough		Anxiety	
Eye redness		Wheezing		Depression	
Eye drainage		Shortness of breath		Thoughts of hurting self or others	
Eye itching		Cough at night			
		Cough after exercise		**EXTREMITY/JOINT**	
				Joint swelling	
HEMATOLOGY		**GENITOURINARY**		Joint pain	
Easy bruising		Urinary infections		Joint stiffness	
Easy bleeding		Kidney disease			