AAIC Asthma, Allergy & Immunology Center

New Patient Visit

DATE: _____ TIME IN: _____ TIME OUT: _____ ACCT#: _____

Name: _____ Age: _____ Sex: M/F Married:
Date of Birth: _____ Single:
PCP/Referring M.D.: _____ Referred by a friend/Self
Local pharmacy of choice: _____ Mail Order pharmacy: _____
If a **minor**, accompanied by: (name) _____

Reviewed Medical Records from referring Physician/ PCP/ Specialists YES/NO

Drug Allergies: (Attach list)
_____
_____

Food Allergies: (Attach list)
_____
_____

Current Meds: (Attach list)
_____
_____
_____

Previous Meds: (Attach list)
_____
_____
_____

- Asthma meds (Circle what applies)
  - Inhalers _____
  - Singulair _____
  - Nebulizer _____

- Allergy meds (Circle what applies)
  - Nose sprays _____
  - Antihist._____
  - Eye drops _____
  - Singulair _____
- Meds for Acid Reflux/Heartburn: _____
- Meds for Hives/Swelling: _____
- Meds/Creams/Lotions for Eczema/Atopic Dermatitis: _____
  _____

Skin Test/Allergy Blood Test: Date: _____ By Whom: _____
Allergy shots: _____ Stinging Insect _____ Fire Ant
How long: _____ When stopped: _____ __ Shots helping: Y/N

Previous X-rays(Yes/No) CHEST/date: _____ SINUS/date: _____
Previous CT Scans(Yes/No) CHEST/date: _____ SINUS/date: _____

NAME: _____DOB:_____ DATE: _____ ACCT# _____

CHIEF COMPLAINTS:

HISTORY OF PRESENTING COMPLAINTS:

NAME: _____DOB:_____ DATE: _____ACCT# _____

PAST HISTORY: Circle all that applies:

GENERAL

RECURRENT INFECTIONS

None

Recurrent ear infections? Yes/No — Recurrent sinus infections? Yes/No

Recurrent URI/LRI infections? Yes/No — How many per year?____

Recurrent pneumonias? Yes/No

Recurrent skin infections/ Abscess? Yes/No — How many?_____

Other infections? _____

EAR INFECTIONS: Age of onset: — How many per year: _____

Since when:_____

Do infections clear quickly with antibiotics? — Yes / No

Tubes in Ears: Yes/No — (Dates): _____

How many sets: _____ — Did tubes help? Yes/No

Vertigo/Imbalance: How long?_____ — Meniere's Disease: Yes/No

Hearing Loss: Permanent /Intermittent. — Hearing screening: Yes/No

ADENOIDECTOMY/TONSILLECTOMY:

Speech: Appropriate / Delayed — Speech Therapy: Yes/No

SINUS INFECTIONS: Age of onset: _____ — How many per year: _____

Do infections clear with antibiotics? Yes / No

Sinus/Nasal polyps: Yes/No

Sinus surgery / irrigation: Yes/No — How many times: _____

Dates: _____ — Name of ENT: _____

HEADACHES/Migraine : Yes/No Age of onset: _____ How often: _____

BRONCHIAL ASTHMA: Age of onset: _____ Well controlled: Yes/No

Have you ever had (circle all that apply)

Frequent ER visits: Yes/No — Prior hospitalizations/ICU admissions: Yes/No

Date: _____ — Date: _____

Prior intubations: Yes/No — Prior oral steroid use: Yes/No

Cough / wheeze / short of breath at rest / or with activity: Yes/No

Lung Function Tests: Yes/No — Date: _____

By whom: _____

Aspirin /NSAIDs allergies: Yes/No — Nasal/Sinus polyps: Yes/No

PNEUMONIA: How often: _____ — Please give dates: _____

Right / Left / Both sides — Chest x-rays/CT scans

# of hospitalizations: _____ — Dates: _____

NAME: _____ DOB:_____DATE: _____ACCT #_____

If you have Hives, fill out this page and proceed. If not, just proceed

URTICARIA (HIVES)
SKIP THIS SECTION IF YOU DO NOT HAVE HIVES

- How long have you had hives? _____
- First episode of hives? _____ Last episode? _____
- How often do you break out into hives? _____
- Where do you break out in hives: Arms/Legs/Hands/Feet/Face/Torso/All over
- Size of hives: pin-head/dime/quarter/large/irregular/streaks/red: _____
- How long do the hives last? Less than 12 hours/less than 24 hours/or several days? _____
- What triggers the hives? _____
- Do the hives itch? _____
- Are the hives painful? _____
- When the hives go away, do they leave bruise marks? _____
- Have you had lip, tongue or throat swelling, hand and feet swelling, nausea, vomiting or stomach pain along with the hives? _____
- What medications have you tried for the treatment of hives: Atarax/ Benadryl/ Claritin/ Zyrtec/ Allegra/ Singulair/ Prednisone/ Pepcid/ Zantac _____
- Do you have any body piercings? _____
- Have you been to the ER for treatment of hives? _____
    - How many times? _____ Last ER visit: _____
- Do you also have: "colds/infections along with hives
  Cold intolerance/ constipation/ weight gain
  Fatigue – how long? _____
  Joint pain/ muscle pain _____
  Any hair loss/ mouth ulcers _____
  Large local reactions to mosquito or ant bites _____
- Family history of Lupus/ Rheumatoid Arthritis/ Sjogren's _____
- Recent Blood tests/ Chest or Sinus X-rays / Colonoscopy/ Pap smear/ Mammogram/ PSA/ Skin biopsy/ Patch Test _____

_____ _____
NURSE Physician

NAME: _____DOB:_____ DATE: _____ACCT# _____

SURGICAL HISTORY:

_____
_____
_____

HOSPITALIZATIONS:

_____
_____
_____

EMERGENCY ROOM VISITS:

_____
_____
_____

PSYCHOSOCIAL: (Home situation)

_____
_____

FAMILY HISTORY: (circle all that applies)
Do parents, grandparents, siblings, or children have the following:

Asthma	Allergies	Alpha-1 antitrypsin deficiency
Chronic infections	Eczema/ Atopic Dermatitis	Emphysema
Sinusitis	Immune deficiency	Thyroid disease
Cystic Fibrosis	Sarcoidosis	Diabetes
Hypertension	Lupus	Rheumatoid Arthritis
Heart Disease	Cancer	Alcoholism
Depression	Memory Loss	Migraines

Travel History:
Any recent travel out of state or out of the country_____

REVIEW OF SYSTEMS: (Please circle the appropriate answer)
GENERAL: Unexplained Weight (gain /loss) Fatigue Unexplained Fever

EYES: Itching Watering Burning Redness Dry

EARS: Popping Itching Ache Fluid PETs
Imbalance Vertigo Wax Discharge

NOSE/ SINUS: Blocking Running Sneezing Sniffling
Nasal/ Sinus Polyps Nose Bleeds Allergy salute Snoring
Mouth Breathing/Dryness. Ansomia/Dysosmia
Perennial Seasonal –Spring/Summer/Winter/Fall

THROAT: PND Itching Soreness Dry
Hoarseness of Voice Bad breath

NAME: _____DOB:_____ DATE: _____ACCT# _____

(Please circle all that applies)

NECK: Lymph node enlargement / pain Thyroid gland enlargement

HEADACHE: Frontal/Temporal/Top of Head/In between orbits Nuchal Pain
Aura Triggers: _____
Pounding/Dull/Throbbing Frequency: _____
Nausea/Vomiting with headaches? Yes/No Blurred vision: Yes/No
Night / Early AM / Evening / All day Relieved with: _____
CT / MRI of head Name of Neurologist: _____

CARDIAC: HBP Rheumatic Fever Heart murmur / MVP
Chest pain Character of pain: Constant / Intermittent
Radiation of pain Relation to respiration
Palpitations Dyspnea/Orthopnea Past ECG or other heart tests
Name of Cardiologist: _____

LUNGS: Cough (dry/productive) Sputum: Color _____Quantity: _____
Blood in sputum (Y/N)
Day: (with activity) / (without activity)
Night: when laying down during sleep early morning

GI: Nausea / Vomiting Diarrhea / Constipation Appetite Abdominal pain
Rectal bleeding Liver or gallbladder trouble Excessive belching

GU: Polyuria Nocturia Bladder Infections Stones
Blood in urine LMP_____

MUSCULOSKELETAL: Muscle or joint pain Stiffness Arthritis Backache

HEMATOLOGIC: Anemia Easy bruising Past blood transfusions

ENDOCRINE: Thyroid problems Heat / Cold intolerance Diabetes

PSYCHIATRIC: Neuroses Mood Swing Depression Memory Loss

SKIN: Eczema Poison Ivy Rosacea Dry skin Atopic/Contact Dermatitis
Hives

NAME: _____DOB:_____ DATE: _____ACCT# _____

BIRTH HISTORY / INFANT FEEDING/ PEDIATRICS:

GESTATIONAL AGE: Term (37-42 wks) Pre Term (<37 wks) Post Term (>42 wks)
Complications: _____
Birth weight: _____ Length: _____ Nursery Stay:_____
Assisted breathing: _____

FEEDING HISTORY: Breast Fed: Yes/No How many months? _____
Formula fed/ supplemented (Yes/No)
Milk based formula/Soy formula/Other_____
Allergy to Formula/Baby Food/Table Food

DELIVERY: Normal C-Section
Umbilical cord separation: Normal / Delayed (more than 6 weeks)
Rash at first month of birth: Yes/No
Growth and Development: Normal / Delayed
(Provide immunization records)

Immunizations:	Up to date	Yes / No - Requires _____
Prevnar /Pneumovax	Influenza	Varivax

ENVIRONMENTAL / SOCIAL HISTORY:

Alcohol/Drugs:	Frequency:	Duration of use:
House / Apartment / Mobile Home		Carpet: Old / New
Lived in for how long?		fully / partially
Location	Rural / Urban	Pets: Cats: in/out
Mattress:	Encased Yes / No	Dogs: in/out
Pillows:	Feathered/Other	Other: in/out
Bed Spread:	Down/Poly fill	Heat: Central
		Space Heaters
		Electric / Gas / Kerosene
Indoor plants:	How many	Air conditioning: Central / Window
Fan/Ceiling Fans	Yes/No	Filters changed frequently? Yes/ No
Venetian Blinds	Drapes (Light/Heavy)	Stuffed Animals? Yes / No

If you are a NON SMOKER, SKIP this section.

Smoking History:
If you are a smoker, please fill out the questions below
Tobacco use: _____ years

Smokes cigarettes? Yes/No	If yes, how many packs a day? _____
Smokes pipe? Yes/No	Uses chewing tobacco? Yes/No
Smokes Cigars? Yes/No	Smoke marijuana: Yes/No

NAME: _____ DOB:_____DATE: _____ACCT #_____

Smoking History continued:

Have you
Have you tried to quit? Y/ N
If yes, when did you quit? _____
If not, would you like to quit? Y/ N
Second hand tobacco exposure

None	Minimal
Frequent	Daily
Family member smokes indoors / in car	Family member smokes outdoors only
Caregiver smokes indoors / in car	Caregiver smokes outdoors only

Occupation: _____ Years at current occupation: _____
Occupational exposure to Dust/Smoke/Irritants
# of work days missed this year: _____

Hobbies: _____ Outdoor activities: (_____%)

Attending Day Care since_____ How many days a week: _____
# of children in class/group: _____

School Grades: Good/Above Average/Average/Poor
# of school days missed this year:_____

Has your illness impacted your quality of life: Yes/No
If yes, please explain: _____

_____ _____
Nurse Date

_____ _____
Prem K. Menon, M. D. Date
FAAAAI, FACAAI, FAAP

_____ _____
Vimla Menon, M. D. Date
FAAAAI, FACAAI, FAAP