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New Patient History and Physical. **Today's Date_____**

We want to obtain a good history of your medical problems so that we can develop the best treatment plan for you. So, please complete the following pages, front and back until you come to "STOP". If you don't understand an item on the form, please leave it blank and tell us during the interview.

Please PRINT with ink or ball point pen. (Do not use pencil)

Name: _____
First MI Last

Address: _____

City: _____ State: _____ Zip code: _____

Date of birth ____/_____/_____ Age: _____ Sex: ❑ F ❑ M

Who came with you today? _____ Relationship_____

Contact Details:

Home: _____
Work: _____
Cell: _____
Email: _____

Pharmacy Information:

Name: _____
Address: _____
_____
Pharmacy Number: _____

_____ **MD, DO** _____ _____ _____
Primary care physician's full name Phone Physician's Assistant/Nurse Practitioner Phone

Who referred you, or how did you hear about our office?
❑ Primary care physician ❑ Physician's Assistant ❑ Family Nurse Practitioner ❑ Self-referred
❑ Yellow Pages/Phone Book ❑ Newspaper ❑ Insurance ❑ Website: mybestallergist.com ❑ Urgent Care
❑ Emergency Room (Parkview/St. Mary Corwin/Other)
❑ Friend/Relative Name: _____ Phone Number: _____

Do you have Insurance? ❑ Yes ❑ No Name of Insurance: _____ Deductible: _____ How much have you met on your deductible? _____

Briefly describe the reason for your visit and what you hope to accomplish:

Are you concerned about: ❑***Headache*** ❑***Food Allergy*** ❑ ***Hives***

In the last 5 days, have you taken any antihistamine (examples: Allegra, Claritin, Zyrtec, Tavist Allergy, Benadryl, Actifed, Nyquil, etc.)? ❑ Yes ❑ No. Not sure If so, when? _____

Physician's/Provider's initials _____

- ***Tell us about how bad your cough has been in the last 4 weeks by marking an (X) in the box on the 0-5 scale***

	0 None	1 Mild	2	3 Moderate	4	5 Severe
How bad is your cough?						
Cough at bedtime?						
Cough when you first wake up?						
Cough in your sleep?						
Cough after exercise?						
Cough when you talk for prolonged about of time?						
Cough when you laugh?						
Cough when you sing?						
Cough when you cry?						
Cough when you drink or eat something cold?						
Cough when you go outside in the cold weather?						
Cough when you have cold viral infection?						

- ***When you catch a cold, do you develop a severe cough: ☐ Yes ☐ No***
- ***How long does the cough last?*** _____
- ***How often does it occur in a year?*** _____
- ***What time of the year does it occur?*** _____ ***Spring*** _____ ***Summer*** _____ ***Fall*** _____ ***Winter***
- ***Tell us about other respiratory symptoms you have had in last 4 weeks by marking a (X) in the box on the 0-5 scale:***

	0 None	1 Mild	2	3 Moderate	4	5 Severe
Wheezing						
Shortness of breath						
Mucus/Phlegm						

Can you estimate the amount of the phlegm you produce in teaspoonfuls? _____ **teaspoon (s)**

Do you use an albuterol HFA or a nebulizer? ❑ Yes ❑ No If yes, how often?

❑ 3+ times a day ❑ 1-2 times a day ❑ 2-3 times a week ❑ less than once a week

- ***Tell us about your nasal/sinus symptoms you have had in the last 4 weeks by marking an X in the box on the 0- 5***

	0 None	1 Mild	2	3 Moderate	4	5 Severe
Runny nose						
Stuffy nose						
Sneezing						
Itchy/Watery eyes						

- ***Are your respiratory symptoms worse at certain times of the year? If so, please mark an X in the months it worsens.***

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Wheezing												
Shortness of Breath												
Mucus/Phlegm												

How is your sense of smell? ❑ Normal ❑ Decreased ❑ Non-Existent

Physician's/Provider's initials _____

Does your nose run with clear water like a faucet? ❑ Yes ❑ No
Does your nose run more when you bend over? ❑ Yes ❑ No
Have you undergone nasal or sinus surgery? ❑ Yes ❑ No If so, when? _____
Any injury to the head? ❑ Yes ❑ No If yes, when? If so, _____

CHRONIC MEDICAL PROBLEMS: Please list all of your medical conditions, even if controlled with medication

PERSONAL

Education: Grade School ___ grade High School 1 2 3 4 College 1 2 3 4 _____

Marital Status: ❑ Single ❑ Married/Partner ❑ Divorced ❑ Separated ❑ Widowed

Children: ❑ Yes ❑ No If yes, how many? _____

Race/Ethnicity: _____ Preferred Language: _____

Occupational History:

Job Title	Dates of Employment	Description	Health Risks/Exposures	Injuries Illnesses

Are you exposed to anything at work that might aggravate your condition? ❑ Yes ❑ No. Which things? _____

Do your symptoms get worse at work? ❑ Yes ❑ No

Are your symptoms better on weekends, holidays, or on your days off? _____

Environmental History

What do you do to cool your home?: ❑ Central Air ❑ Swamp Cooler ❑ Open Windows ❑ Fans

What do you do to heat your home?: ❑ Furnace ❑ Fire Place/Wood Burner ❑ Radiant Flooring ❑ Baseboard heat

Are you aware of any exposure to the following?: ❑ Mold ❑ Water Damage ❑ Candles ❑ Air Fresheners

Other exposures of concern? _____

Pets (Please indicate how many?)

❑ Dogs # _____	❑ Indoor	❑ Outdoor	❑ Indoor/Outdoor	❑ In Bedroom
❑ Cats # _____	❑ Indoor	❑ Outdoor	❑ Indoor/Outdoor	❑ In Bedroom
❑ Birds # _____	❑ Indoor	❑ Outdoor	❑ Indoor/Outdoor	❑ In Bedroom
❑ Other # _____	❑ Indoor	❑ Outdoor	❑ Indoor/Outdoor	❑ In Bedroom

Previous Allergy Evaluation and Therapy

Have you ever had allergy skin tests? ❑ Yes ❑ No

Date _____ Physician's Name _____ Results: _____
(If possible, please provide us with a copy)

Have you ever received allergy injections? ❑ Yes ❑ No Dates _____

Exercise

Do you exercise regularly? ❑ Yes ❑ No How often? _____

Physician's/Provider's initials _____

Fill out the birth history if the patient is younger than 16 years of age.

Birth weight: _____ lbs. _____ oz. Any complications during pregnancy or delivery? _____

Is growth normal? ❑ Yes ❑ No

Any feeding problems? ❑ Yes ❑ No

Immunization History (check type of vaccine and most recent administration)

❑ Influenza Vaccine (flu shot) Last given _____

❑ Pneumococcal Vaccine (pneumonia shot) Last given _____

❑ Tetanus & Diphtheria Last given _____

Medications: Prescriptions/OTC/Herbals/Vitamins/Supplements (list all)

No	Medication Name	Dose (mg, mcg, ml, etc.)	By mouth, injection, inhalation, etc.	How Often?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

DRUG ALLERGIES: Please list any ADVERSE REACTIONS to drugs:

Name of Drug	When did it happen?	Symptom(s)

Smoking History:

❑ Patient has never smoked

❑ Patient currently smokes: ❑ Cigarettes– _____ pks/day ❑ Cigar ❑ Pipe ❑ Marijuana

❑ Patient previously smoked: ❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Marijuana

Age start= _____ Age stop= _____Average packs/day= _____❑ Other forms of tobacco: _____

Smoker(s) in home ❑ Yes ❑ No Who: _____

If your smoking, please discuss with us; we urge you to quit: https://smokefree.gov/quit-smoking/getting-started/steps-to-manage-quit-day Also you can call 1-800-QUIT- NOW

Alcohol or Substance Use:

Do you drink alcohol? ❑ Yes ❑ No If so, how much?: _____ (# per day/week/month)

Any problems with alcohol now or in the past? ❑ Yes ❑ No

Do you use any illegal drugs? ❑ Yes ❑ No

HOSPITALIZATIONS & SURGERIES: *What surgical procedures have you had? (provide year & details, if possible)*

Procedure	Year	Procedure	Year
Sinus Surgery		Heart Surgery (Coronary artery bypass, Valve replacement, pacemaker, etc.)	
Lung Surgery		Other _____	
❑Tonsillectomy ❑ Adenoidectomy		Other _____	
Thyroid Surgery		Other _____	

Family History

Disease	Yes	No	Relation	Comments
Allergies				
Allergic Rhinitis				
Asthma				
Chronic Obstructive Pulmonary Disease/(COPD)				
Cystic Fibrosis				
Emphysema				
Frequent Pneumonia				
Hay fever				
Pulmonary Fibrosis				
Tuberculosis				
Other :_____				

Review of Systems: What symptoms have you experienced in the last 6 months?

Ear, nose, mouth and throat

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Ear Pain/Ache						Mouth Sores					
Ear Infection						Nasal Polyps					
Hearing Loss						Post-Nasal Drip					
Hoarseness in voice						Sinus Pain					
Nosebleeds						Throat Tightness					
Enlarged lymph nodes						Sinus Infections					
If so where?_____											

Lungs and chest symptoms (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Cough productive						Chest Tightness					
What Color? _____						Low Oxygen Levels					
Coughing up blood						Chest X-Ray? ☐ Yes ☐ NO	When?				
Frequent "chest colds''						Other _____					

Blood and Lymph Nodes (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Swollen Glands						Easy bleeding					

Heart (provide frequency and severity— mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Can't lie flat						Chest Pain					
Fainting Spells						Where?_____					
Irregular Heartbeat						Heart Murmur					
Swelling of Ankles						Swelling of Legs					

Physician's/Provider's initials _____

Tell us about the symptoms of GERD you have had in the last 7 days:

Please answer the following questions by circling the number in the corresponding box	**0 day**	**1 day**	**2-3 days**	**4-7 days**
How often did you have a burning feeling behind your breastbone (heartburn)?	0	1	2	3
How often did you have stomach contents (liquid or food) moving upwards to your throat or mouth (regurgitation)?	0	1	2	3
How often did you have difficulty getting a good night's sleep because of your heartburn and/or regurgitation?	0	1	2	3
How often did you take additional medication for your heartburn and/or regurgitation, other than what the physician told you to take? (such as Tums, Rolaids, Maalox?)	0	1	2	3

Genitourinary (provide frequency and severity—mild/moderate/severe

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Excessive Night Urination						Painful Urination					
Frequent urination						Urinary Incontinence					
Difficulty Urinating						Irregular menses (period)					

Muscles and Bones (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Joint Stiffness						Joint Pain					
Muscle Pain						Joint Swelling (which joint?)					

Neurologic (Brain) (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Concentration Problems						Tremor					
Weakness						Memory Problems					
Numbness (Where?)						Seizures					

Fall Risk Assessment

Please answer the following questions	**Yes**	**No**
Have you fallen in the past year?		
Do you have difficulty getting around, or with balance?		
Are you afraid of falling?		

Sleep (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Excessive Daytime Sleepiness						Insomnia					
Snoring						Stop Breathing in Sleep					

Psychologic (Mood) (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?
Anxious/Worried					
Mood Swings					
Panic Attacks					

Depression Screening Questions

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Over the past 2 weeks, how often have you been bothered by any of the following problems?				
Little interest or pleasure in doing things.				
Feeling down, depressed, or hopeless				

STOP

Physician's/Provider's initials _____

Patient's Name: _____ ***Nickname***: _____ **Date**: _____

Who came with you today? _____

Name of insurance paying for your prescriptions: _____

Did the patient take antihistamines in the last 4 days? ❑ **Yes** ❑ **No** ***If yes, give date***: _____

Can the child swallow tablets? ❑ **Yes** ❑ **No**

❑ **Show the Video!**

Main MA_____ Helping MA_____ Intake MA_____ ❑ **Give the welcome binder!**

VITAL SIGNS: Height_____ cm. Weight: _____ Kilo. Temperature: _____C. Pulse: _____/minute.

Respirations: _____ /minute. Blood Pressure: _____/_____ mmHg O2 Sat: _____%

Assessment	**Plan**

Procedures Completed: Please check the procedures that were done in the office at today's visit.

❑ Skin test (Inhalants) ❑ Skin test (Foods) ❑ Intradermal ❑ Spirometry (Pre) ❑ Spirometry (Post) ❑ Nebulizer Treatment

❑ EKG ❑ Pulmonary Stress Test ❑ Fiberoptic Nasopharyngolaryngoscopy ❑ Albuterol ❑ Albuterol ❑ DuoNeb

❑ Pneumococcal/Influenza vaccine ❑ Skin Scraping ❑ Skin Biopsy ❑UA

Physician's/Provider's initials _____

HEALTH EDUCATION				
DATE:	**Yes**	**No**	**MA's Initials**	**Comments**
Asthma:				
1. Advair/Dulera/Symbicort/Breo/Anoro Flyer				
2. Two ICS consent form				
3. Singulair Flyer				
4. Hands on use of inhalers				
5. Short course of Prednisone form				
6. Asthma Slides				
7. Recommend Influenza Vaccine				
8. Recommend Pneumococcal Vaccine				
Urticaria:				
1. Explain urticaria and hives are the same				
2. Review urticaria website				
3. Go over multiple antihistamine form				
4. Skin Care				
5. Punch Biopsy Consent				
Allergy				
1. Give copy of skin test				
2. Allergy Injection Program consent				
Anaphylaxis				
1. Epi Pen Training				
2. Anaphylaxis Form • Medical ID www.identifyyoursel.com (800) 343-5985 • E-Mail website FAAN www.foodallergy.org				
Sinus				
1. Scope Consent				
Radiology/ Labs				
1. Lab Slip Given (Explain: address, fasting, no appt needed)				
2. Chest X-ray slip given (Explain: address, no appt needed)				
Before Patient Leaves				
1. Explain paperwork twice				
2. Instructions for medication				
3. Note for school				
4. Prescriptions sent to pharmacy/ or written script given				

I will keep my follow-up appointments as advised. If I do not keep my appointments, I can develop poor outcomes. Why? Depending on my progress, during follow-up visits:

1. Dr. Patel can change my medications, for example, add new ones, or stop them.
2. Dr. Patel can add more tests to confirm or revise the diagnosis.
3. Dr. Patel can refer me to another doctor.
4. Dr. Patel may have some other ideas.

I understand that if I do not keep my follow-up appointments, I can suffer poor outcomes.

_____
Patient Signature

_____
M.A.'s Signature

Physician's/Provider's initials _____

Asthma Education

Patient Name: _____ **Date of Birth:** ___/____/___ Date: ___/____/___

	Initial
1. Quick Relief	
2. Rescue/ Reliever medications	
3. Controller Medications	
4. Combination Medications	
5. Anticholinergic	
Asthma Devices	
1. How to use a Diskus inhaler	
2. How to use a peak flow meter	
3. How to use an HFA inhaler	
4. How to use a spacer/ with mask	
Managing Your Asthma	
1.Asthma Warning Signs	
A. Early signs of asthma	
- Mood changes	
- Change in facial features	
- Verbal complaints	
- Breathing Changes	
B. Signs of Moderate Asthma	
- Signs as asthma worsens	
C. Signs of Severe Asthma	
2. Teamwork: Your Asthma Care Team	
A. You play an active role	
B. Doctor/ Staff	
3. Exercise Induced Asthma	
4. Asthma School Form	
Asthma Triggers	
1. Asthma triggers	
A. Allergens	
B. Respiratory infections/ cold/ flu	
C. Inhaled irritants	
D. Exercise	

	Initial
Screening for Fall Risk?	
Counselling for tobacco use?	
Counselling for BMI?	
1. Asthma Myths	
A. It's better to "tough it out" without taking asthma medication	
B. Steroids used in asthma are dangerous.	
C. Sports and physical activity make asthma worse.	
D. Everybody's asthma is the same.	
E. Asthma is an emotional illness.	
2. What is Asthma?	
A. Two things occur in the lungs with asthma:	
- inflammation (irritation)	
- Constriction	
B. Symptoms of an asthma flare-up	
- wheezing	
- coughing	
- chest tightness (hard to breathe)	
- waking up coughing	
- extra phlegm and mucus	
C. If asthma is not treated well it can cause problems including:	
- visits to the emergency room	
- hospitalization	
- inability to participate in sports, etc	
- missed school/ work	
- lung damage	
- in severe cases death	
Vaccination (Immunizations)	
1. Flu Shot - every fall/ winter	
2. Pneumococcal (PPSV23) age 19-64 years 583-4300	

Patient Signature _____ **Date:** ___/____/___

M.A.'s Signature _____

Physician's/Provider's initials _____