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Trained at National Jewish Hospital, Denver

New Patient Form **Today's Date**_____

We want to obtain a good history to develop the right treatment plan for you or your child. Please complete the following pages, front and back until you come to "STOP". If you don't understand an item, tell us during the interview.

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

Name: _____ *Date of Birth:* ____/___/_____ *Age:* ____ Male Female
First *Middle Initial* *Last*

Address: _____ *City:*_____ *State:* _____ *Zip Code:* _____

Home #: _____ *Cell #:* _____ *Work #:* _____

Email Address: _____

Name of person with you: _____*Your relationship with the person:* _____

Pharmacy: Name: _____ *Address:* _____

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

How did you hear about Dr. Patel?
*Name:*_____ *Phone #:*_____

Please tell us the reason for your visit and what you hope to accomplish?

In the last 5 days, have you taken any antihistamine such as Allegra, Claritin, Zyrtec, Xyzal, Benadryl, Actifed, Nyquil?
❑ Yes ❑ No. ❑Not sure. If you took antihistamine recently, how many days ago? _____

Please ask for forms for Hives or Food and Drug Allergy, if you want those health problems to be evaluated.

- **Have you been diagnosed with asthma**? ☐Yes ☐No If yes, when? _____
  - Do you use or have you used in the past an albuterol HFA or a nebulizer? ☐ YES ☐ NO
  - If yes, how often? ☐ 1-2 times a day ☐ 3+ times a day ☐ 2-3 times a week ☐ less than once a week

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- ***Tell us about your cough in the last 4 weeks by marking an (X)in the appropriate box***

	None	***Mild***	***Moderate***	***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 prolong amount of time?	☐	☐	☐	☐
▪ Cough when you laugh?	☐	☐	☐	☐
▪ Cough when you sing?	☐	☐	☐	☐
▪ Cough when you cry?	☐	☐	☐	☐
▪ Cough when you drink or eat something cold?	☐	☐	☐	☐
▪ Cough upon cold air exposure?	☐	☐	☐	☐

- **Chest colds:**
  - When you catch a cold, do you develop a severe cough: ☐ Yes ☐ No
  - How many days the cough will last? _____
  - How many episodes of chest colds in a year? _____
  - What time of the year? _____ Spring _____ Summer _____ Fall _____ Winter

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- **Other respiratory symptoms in last 4 weeks:**

	None	**Mild**	**Moderate**	**Severe**
▪ Wheezing	☐	☐	☐	☐
▪ Chest congestion	☐	☐	☐	☐
▪ Shortness of breath	☐	☐	☐	☐

  - If you have phlegm from the chest (not nose), guess the amount of the phlegm in 24 hours:_____ teaspoon(s)

- **Nasal/sinus symptoms?**

	None	Mild	Moderate	Severe
▪ Runny nose	☐	☐	☐	☐
▪ Stuffy nose	☐	☐	☐	☐
▪ Sneezing	☐	☐	☐	☐
▪ Itchy eyes	☐	☐	☐	☐
▪ Watery eyes	☐	☐	☐	☐

- Does your nose run like a faucet, with water-like discharge? ☐ Yes ☐ No
- Does your nose run when you bend over? ☐ Yes ☐ No
- Does your nose run only on one side? ☐ Right ☐ Left
- Does your pillow get stained because of runny nose at night? ☐ Yes ☐ No
- Does your nose run mostly in winter, upon exposure to cold air? ☐ Yes ☐ No
- Any injury to the head? ☐ Yes ☐ No If yes, when? _____
- Have you undergone any nasal or sinus surgery? ☐ Yes ☐ No If yes, when? _____

- How is your sense of smell? ☐ Normal ☐ Decreased ☐ None
- Have you been diagnosed with Nasal Polyps? ☐Yes☐ No If yes, when? _____
- Number of nasal polyp surgeries? _____

- **Are your respiratory symptoms worse at certain times of the year?**

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
▪ Nasal symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
▪ Eye symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
▪ Chest symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PREVIOUS ALLERGY EVALUATION AND TREATMENT:

- Have you ever had an allergy skin test? ☐ Yes ☐ No If yes, when? _____
- Have you ever received allergy injections? ☐ Yes ☐ No If yes, when? _____
- Have you undergone any Chest X-Ray's? ☐Yes ☐No If yes, when? _____ Where? _____
- CT of the Chest? ☐Yes ☐No If yes, when? _____ Where? _____
- Have you coughed up blood in the sputum? ☐Yes ☐ No

SLEEP:

Excessive Daytime Sleepiness ☐ Yes ☐ No Insomnia ☐ Yes ☐No

Snoring ☐ Yes ☐ No Stop Breathing in Sleep ☐ Yes ☐ No

Do you use supplemental oxygen? ☐ Yes ☐ No

- **OTHER MEDICAL PROBLEMS:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- **MEDICATIONS: If you attach the list of medications, you do not have to write the name of medications below.**

	Prescription Medication Name:	Dosage:	Route: (oral, inhalation, etc.)	How often:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____
11.	_____	_____	_____	_____
12.	_____	_____	_____	_____
13.	_____	_____	_____	_____
14.	_____	_____	_____	_____
15.	_____	_____	_____	_____

- Over the counter/herbal/supplements: **If you attach the list of medications, you do not have to write the name of medications below.**

	Prescription Medication Name:	Dosage:	Route: (oral, inhalation, etc.)	How often:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

- **PERSONAL/SOCIAL HISTORY**:
  - Marital status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed
  - Children: ☐ Yes ☐ No
  - Pets: ☐ Dogs ☐ Cats ☐ Birds ☐ Other: _____
  - Race/Ethnicity: _____ Preferred Language: _____

- **ENVIRONMENTAL/OCCUPATIONAL HISTORY:**
  - Occupations, current and past: _____
  - Are you exposed to anything at work that might aggravate your condition? ☐ Yes ☐ No
    If yes, please give more information? _____
    Are your symptoms better on off days, weekends, holidays, vacation? ☐ Yes ☐ No
  - What do you do to cool your home? ☐ Central Air ☐ Swamp Cooler ☐ Open Windows ☐ Fans
  - Are you aware of any exposure to the following: ☐ Candles ☐ Air Fresheners ☐ Any other strong odors ☐ Anything else? _____
  - Other exposures of concern:_____

- **ADVERSE REACTIONS TO DRUGS:** Please list any adverse reactions to drugs:

	Name of Drug	Symptoms?	When?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

- **SMOKING HISTORY (if it applies):**
  - Do you currently smoke? ☐ Yes ☐ No☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Marijuana ☐ E-cig ☐ Vape ☐ CBD
  - Have you smoke in the past? ☐ Cigarettes __pk __/day ☐ Cigar ☐ Pipe ☐ E-cig ☐ Marijuana ☐ Vape ☐ CBD
  - Age started: _____ Age Stopped: _____ Average packs/day: _____
  - Total no. of years you smoked: _____
  - Smoker(s) at home: ☐ Yes ☐ No Who: _____
  - If you are smoking, please quit: https://smokefree.gov/quit-smoking/getting-started/steps-to-manage-quit-day or call 1-800-QUIT- NOW

- **ALCOHOL OR SUBSTANCE USE:**
  - Do you drink alcohol? ☐ Yes ☐ No If yes, _____ day _____ week _____ month _____ year
  - What do you drink? _____
  - Have you had any problems with alcohol? ☐ Yes ☐ No
  - Do you use any illegal drugs? ☐ Yes ☐ No

- **FAMILY HISTORY:**

	Name of Disease:	Your Relationship:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

- **HOSPITALIZATIONS & SURGERIES:**
  - Sinus Surgery ☐ Yes ☐ No If yes, When? _____
  - Lung Surgery ☐ Yes ☐ No If yes, When? _____
  - Tonsillectomy ☐ Yes ☐ No If yes, When? _____
  - Adenoidectomy ☐ Yes ☐ No If yes, When? _____
  - Others? _____

- **FALL RISK ASSESSMENT:**
- Have you fallen in the past year? ☐ Yes ☐ No

  Do you have difficulty getting around, or with balance? ☐ Yes ☐ No

  Are you afraid of falling? ☐ Yes ☐ No

  Please contact other providers for further evaluation and treatment.

- **DEPRESSION SCREENING:**
- Do you have a diagnosis of Depression? ☐ Yes ☐ No If yes, When? _____

  Are you currently taking a medication for depression? ☐ Yes ☐ No

  Over the past 2 weeks, have you been bothered by any of the following problems?

  Little interest or pleasure in doing things? ☐ Yes ☐ No

  Feeling down, depressed, or hopeless? ☐ Yes ☐ No

- **IMMUNE SYSTEM:**

  - **Adults (Ages 18+) Please answer the following questions**
    - Two or more new ear infections within 1 year ☐ Yes ☐ No
    - Two or more new sinus infections within 1 year, in the absence of allergy ☐ Yes ☐ No
    - One pneumonia per year (x-ray proven) for more than 1 year ☐ Yes ☐ No
    - Chronic diarrhea with weight loss ☐ Yes ☐ No
    - Recurrent viral infections (colds, herpes, warts, condyloma) ☐ Yes ☐ No
    - Recurrent need for intravenous antibiotics to clear infections ☐ Yes ☐ No
    - Recurrent, deep abscesses of the skin, lymph nodes or internal organs ☐ Yes ☐ No
    - Persistent thrush or fungal infections on skin or elsewhere ☐ Yes ☐ No
    - Infections with normally harmless tuberculosis-like bacteria ☐ Yes ☐ No
    - A family history of primary immunodeficiency ☐ Yes ☐ No

  - **Child (Ages 0-17) Caretaker please answer the following questions**
    - Four or more ear infections within 1 year ☐ Yes ☐ No
    - Two or more severe sinus infections within one year ☐ Yes ☐ No
    - Two or more months of antibiotic treatment with little effect ☐ Yes ☐ No
    - Two or more pneumonias per year ☐ Yes ☐ No
    - Insufficient weight gain or growth delay ☐ Yes ☐ No
    - Recurrent deep skin or organ abscesses ☐ Yes ☐ No
    - Persistent thrush in mouth or fungal infection on skin ☐ Yes ☐ No
    - Need for intravenous antibiotics to clear infections ☐ Yes ☐ No
    - Two or more deep seated infections ☐ Yes ☐ No
    - A family history of a primary immunodeficiency ☐ Yes ☐ No

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REVIEW OF SYSTEMS (Please talk to your primary care provider for evaluation of the following symptoms/issues)

- **Ear, nose, mouth and throat:**

Earache ☐ Yes ☐ No
Mouth Sores ☐ Yes ☐ No
Ear Infections ☐ Yes ☐No _____ per year
Throat Tightness ☐ Yes ☐ No
Hearing Loss ☐ Yes ☐ No
Hoarseness ☐ Yes ☐ No
Nosebleeds ☐ Yes ☐ No
Enlarged Lymph nodes ☐ Yes ☐ No

- **BLOOD AND LYMPH NODES:**

Easy Bleeding ☐ Yes ☐ No

History of blood infection ☐ Yes ☐ No

- **HEART:**

Shortness of breath ☐ Yes ☐ No

Ischemic heart disease ☐ Yes ☐ No

Irregular Heartbeat ☐ Yes ☐ No

Swelling of Ankles/Legs ☐ Yes ☐ No

- **STOMACH:**

Do you have a burning feeling behind your breastbone (heartburn)? ☐ Yes ☐ No

Do the contents of your stomach move upwards to your throat or mouth (regurgitation)? ☐ Yes ☐ No

Do you have difficulty getting a good night's sleep because of your heartburn and/or regurgitation? ☐ Yes ☐ No

Do you take additional medication for your heartburn and/or regurgitation, other than what the physician told you to take? (such as Tums, Rolaids, Maalox?) ☐ Yes ☐ No

Spleen removed? ☐ Yes ☐ No

- **GENITOURINARY:**

Urinary Tract Infections ☐ Yes ☐ No _____ per year

- **MUSCLES AND BONES:**

Joint Stiffness ☐ Yes ☐ No

Joint Swelling ☐ Yes ☐No

Joint Pain ☐ Yes ☐ No

- **NEUROLOGIC (BRAIN):**

History of Meningitis ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

- **PSYCHOLOGIC (MOOD):**

Mood Swings ☐ Yes ☐ No

Panic Attacks ☐ Yes ☐ No

I understand that Dr. Patel will not evaluate and treat all the symptoms I have marked above in this form. After he talks to me and examines me, he will decide which symptoms and medical problems he will evaluate and treat.

_____ _____

Signature of the Patient/Guardian **Date**

Patient Name: _____ Date:_____

HIVES/ SWELLING Questionnaire

Please answer the following questions only if you have hives or welts; the questions do not apply if you have eczema or rash. If you are not sure, please ask us.

- For how long you have been suffering from hives?_____
- Do your hives come and go? □ Yes □ No
- How long one hive, one spot, lasts before it subsides? _____hours, _____days, _____ weeks?
- Does one hive last more than 24 hours in the same spot? □ Yes □ No
- When the hives go away, does the skin become completely normal? □ Yes □ No
- Is there a bruise mark after the hive subsides? □ Yes □ No
- Are the hives?□ Itchy □ Painful □ Burning □ _____
- Where do the hives occur? □ Face □ Arms □ Trunk □ Palms □ Legs □ Buttocks □ Soles □ Other: _____
- When your hives erupt, do you also develop? □ Aching □ Joint pain □ Chills □ Fever □ Nausea □ Abdominal pain □ Tightness of the throat or chest □ Palpations □ Other: _____
- Do antihistamines control your hives?□ Yes □ No
- What do you believe is causing your hives? _____

- Does any of the following trigger or make your hives worse?

When your body gets warm/hot	□ Yes □ No
Sweating	□ Yes □ No
Exercise	□ Yes □ No
Exposure to cold weather, snow, or ice	□ Yes □ No
Shower or bath	□ Yes □ No
Pressure points such as waistline	□ Yes □ No
Scratching of your skin	□ Yes □ No
Vibration because of vibrating tools	□ Yes □ No
Exposure to the sun	□ Yes □ No
Are your hives worse during menstrual cycle?	□ Yes □ No

- Do you think any food causes hives? □ Yes □ No □ Name of the foods: _____
- Do you think food additives causes hives? □ Yes□ No □ Name of the foods: _____

Sometimes ibuprofen and naproxen (Aleve) can cause or make hives worse.

How often do you take ibuprofen or naproxen (Aleve)? _____ times in a □ Day □ Week □ Month

How many milligrams? □ Ibuprofen _____ □ Naproxen _____

Many patients do not realize the association of ingestion of ibuprofen or naproxen and breaking out of hives. Please try to remember the time you took ibuprofen or naproxen and the time hives developed.

- Did you take ibuprofen or naproxen several hours before the outbreak of the hives? □ Yes □ No
- How many hours before the outbreak of hives did you take ibuprofen or naproxen?_____

_____

- Do you develop swelling of the lip, tongue, eyelid, or other parts of the body? □ Yes □ No
- How long does the swelling last? _____ hours, _____ days, or _____ weeks?
- Do you develop difficulty in breathing because of the swelling of the tongue or throat? □ Yes □ No

Are you taking any of the following medications?

Non-steroidal Anti-inflammatory Drugs: □ Yes □ No

Example of NSAIDS include:

- Ibuprofen (Motrin, Aleve)
- Aspirin (Excedrin)
- Naproxen (Aleve, Naprosyn)

Congestive Heart failure Medication: □ Yes □ No

- Entresto (Sacubitril/valsartan)

Calcium channel blockers for the treatment of heart disease: □ Yes □ No

Examples of calcium channel blockers include:

- Amlodipine (Norvasc) □ Yes □ No
- Diltiazem (Cardizem, Tiazac, others) □ Yes □ No
- Felodipine □ Yes □ No
- Isradipine □ Yes □ No
- Nicardipine □ Yes □ No
- Nifedipine (Adalat CC, Procardia) □ Yes □ No
- Nisoldipine (Sular) □ Yes □ No
- Verapamil (Calan, Verelan) □ Yes □ No

DPP-4 inhibitors: □ Yes □ No

Examples of DPP-4 inhibitors

- Januvia (Sitagliptin) □ Yes □ No
- Galvus (Vildagliptin) □ Yes □ No
- Onglyza (Saxagliptin) □ Yes □ No
- Tradjenta (Linagliptin) – approved for use in the USA □ Yes □ No

ACE Inhibitors for high blood pressure: □ Yes □ No

Examples of ACE inhibitors include:

- Benazepril (Lotensin) □ Yes □ No
- Captopril □ Yes □ No
- Enalapril (Vasotec) □ Yes □ No
- Fosinopril □ Yes □ No
- Lisinopril (Prinivil, Zestril) □ Yes □ No
- Moexipril □ Yes □ No
- Perindopril □ Yes □ No

- Quinapril (Accupril) □ Yes □ No
- Ramipril (Altace) □ Yes □ No
- Trandolapril □ Yes □ No
- Aliskiren (Tekturna) □ Yes □ No

- Sirolimus □ Yes □ No
- Everolimus □ Yes □ No
- Amiodarone □ Yes □ No
- Metoprolol □ Yes □ No
- Risperidone □ Yes □ No
- Paroxetine □ Yes □ No
- Etanercept □ Yes □ No
- Biologics □ Yes □ No
- Inhaled cocaine in uvular angioedema □ Yes □ No

Herbal:

- Garlic □ Yes □ No
- Sanyak □ Yes □ No
- Ecballium elaterium □ Yes □ No

_____ _____

Signature of the Patient/Guardian **Date**

FOOD/DRUG ALLERGY QUESTIONNAIRE

Are you on any special diets? Yes No

Are you avoiding any foods/drugs? Yes No **If yes**, please list in the table below:

Name of Food/Drug			
Amount of Food/Drug Ingested			
Symptoms			
How quickly the symptoms start?	Immediately Within minutes _____ minutes Within hours ____hours Within days _____ days	Immediately Within minutes _____ minutes Within hours ___hours Within days _____ days	Immediately Within minutes _____ minutes Within hours ____hours Within days _____ days
Duration of Symptoms			
What did you do for the treatment?			
Have you eaten the food again?			
If so, was there a reaction again?			

_____ _____

Signature of the Patient/Guardian **Date**

STOP

Patient'sName: _____***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: _____%

Pharmacy Name: _____ Phone #: _____ M.A. initial _____

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 ✈FiberopticNasopharyngolaryngoscopy ✈Albuterol ✈DuoNeb
✈Pneumococcal/Influenza vaccine ✈Skin Scraping ✈Skin Biopsy ✈UA