Middle Georgia Allergy & Asthma, LLC
227 Industrial Blvd., Dublin, GA 31021
Tel – (478) 353 1058

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New Patient Form:

Last Name: _____ First Name: _____

Age:_____ DOB:_____ Today's Date:_____ Gender: ☐ Male ☐ Female

Primary Care Physician: _____

Referred by: ☐ Primary Care Physician ☐ Other Physician – Name: _____

Pharmacy Info: Name:_____ Location:_____ Phone #:_____

Main complaint: _____

Past Medical History:

Please list all current and previous medical problems: _____

_____

_____

List all surgeries and hospitalizations with associated dates:_____

_____

_____

Previous Allergy Testing/Therapy: ☐Skin test ☐Blood test ☐ I have never had allergy testing

Allergy test results and date of test:_____

Allergy Shots in past?: ☐ No ☐ Yes When started: _____ When stopped: _____

Reason for stopping: _____

Box Information For Pediatric patients only:

Birth weight: ___lbs. ___oz. Type of Delivery:_____

Complications during pregnancy, delivery and/or neonatal course: ☐ None ☐ Yes, Explain _____

_____

Immunizations/Vaccinations up-to-date? ☐ Yes ☐ No – Explain:_____

For WOMEN of child-bearing age: Are you pregnant? ☐ No ☐ Yes

Medications:

(Please be ready to list all medications (INCLUDING ALL INHALED MEDICATIONS), vitamins and herbal supplements including doses and frequencies. The nurse will obtain this information from you during your office visit.)

Allergies:

(Please be ready to list all ADVERSE EFFECTS and ALLERGIES to a medication, drug, food, insect, or anything else. Be sure to give the approximate date of the reaction with a description of the reaction. The nurse will obtain this information from you during your office visit.)

Family History:

Please state any medical problems in the family:

Mother: _____ Father: _____

Brothers: _____ Sisters: _____

Other: _____

Social History:

Box information for Pediatric patients only:

Does your child attend day care?: ☐ No ☐ Yes ☐ Not applicable School Grade: _____

Smoking exposure: ☐No smoke exposure ☐Parent, relative or guardian smoke outdoors only

☐Parent, relative or guardian smoke indoors, outside and/or in the car.

Occupation: _____

Tobacco use: ☐ No ☐ Yes – Type:_____

Do you currently smoke? ☐ No ☐ Yes – Number of years____ Number of packs per day _____

If not currently smoking, have you ever smoked in the past: ☐ No ☐ Yes – Number of years smoked___ When did you quit?____

Alcohol use: ☐ None ☐ Yes – Frequency: ☐Occasional ☐Other:_____

Drug use: ☐ None ☐ Yes – Explain:_____

Environmental History:

Do you live in a: ☐House ☐Apartment ☐Other: _____ Age of home/apartment:_____

Length of time living in your home: _____

Check if you have the following:

☐Basement ☐Crawl space ☐History of flooding or water damage in home

☐Obvious mold in home, basement or crawl space ☐Problems with roaches, mice or rats in home

☐Carpet ☐Area rugs ☐Use of dust mite encasements

Heating/Air conditioning/Air Quality:

☐Central forced air conditioning and heating ☐Window unit air conditioning ☐No air conditioning

☐Gas heating ☐Electric heating ☐Other heating – Type: _____

☐Gas stove ☐Electric stove ☐Humidifier ☐Dehumidifier

☐Humidity gauge ☐Vacuum at least weekly ☐Central air filter

☐Portable air filter present ☐HEPA air filter present ☐Fireplace present

Pets:

☐Cat – How many? _____ ☐Dog – How many? _____ ☐Other: _____

Review of Systems:

(Please check any symptoms that you have had in the past 3 months)

Constitutional Symptoms:

☐Fever ☐Chills ☐Fatigue ☐Headaches

☐Night Sweats ☐Decreased appetite ☐Difficulty sleeping ☐Weakness

☐Weight Loss ☐Weight Gain

Eyes:

☐Wear contact lenses ☐Blurred Vision ☐Double Vision ☐ Swelling

☐Excess tearing ☐ Itching ☐ Redness

Ears/Nose/Mouth/Throat:

☐Hearing loss or ringing ☐Earaches or drainage ☐Itching or popping of ears ☐ Sneezing

☐Snoring ☐Nasal congestion ☐Nose Bleeds ☐Sinus pressure

☐Nasal itching ☐Post-nasal drip ☐Runny nose ☐Sore throat

Cardiovascular (Heart):

☐Chest pain ☐Irregular heart beat ☐Heart murmur ☐Heart racing

☐Swelling of legs ☐Shortness of breath lying down

Respiratory (Lungs):

☐Cough ☐Wheezing ☐Shortness of breath ☐Chest tightness

☐Coughing up blood ☐Difficulty getting air OUT ☐Difficulty getting air IN

Gastrointestinal:

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

☐Heartburn ☐Abdominal pain ☐Bright red blood in stools ☐Black stools

Urinary:

☐Frequent urination ☐Painful/burning urination ☐Blood in urine ☐Difficulty stopping urination

☐Difficulty starting urination ☐Large urinary volume

Musculoskeletal:

☐Painful joints ☐Swelling of joints ☐Redness of joints ☐Muscle pain

☐Back pain ☐Pain down back of legs

Integumentary (Skin):

☐Dry Skin ☐Itchy skin ☐Rash ☐Change in skin color

☐Nail changes ☐Change in hair

Neurological:

☐Recurrent headaches ☐Seizures ☐Numbness or tingling ☐Muscle weakness

☐Tremors ☐Loss of sensation ☐Loss of balance ☐Memory difficulty

Psychiatric:

☐Nervousness ☐Depression ☐Confusion ☐Insomnia

Endocrine:

☐Heat/Cold Intolerance ☐Excessive thirst ☐Thyroid swelling/Goiter ☐Glandular or hormone problems

Hematologic/Lymphatic (Blood and Lymph nodes):

☐Easy bleeding ☐Easy bruising ☐Difficult to stop bleeding ☐Enlarged glands/lymph nodes

Allergic/Immunologic:

☐Hay fever symptoms ☐Bee/Wasp/Fire ant allergy ☐Frequent pneumonia ☐Frequent skin infections

☐Drug Allergies: _____ ☐Food Allergies: _____

Other:

☐Other _____