PATIENT INFORMATION SHEET

DATE: _____

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE: _____ CELL PHONE: _____ TEXTS (Y or N): ____

SEX (M, F or T): _____ DATE OF BIRTH: _____/_____/_____ EMAIL: _____

SSN: _____ Race: _____ Ethnicity: _____

MARITAL STATUS: Married_____ Single_____ Divorced_____ Widow(er)_____ Domestic Partner_____

PRIMARY CARE PHYSICIAN: _____ REFERRING DOCTOR: _____

How did you hear about us? _____

MEDICAL HISTORY

What is your main reason for seeing us? _____

When is the last time you took an antihistamine? _____

What is the name of the pharmacy that you use? _____

CURRENT MEDICATIONS:

Name of drug	Dosage	How often taken?

Are you allergic to any medications? No/Yes (IF YES PLEASE LIST MEDICATIONS AND REACTIONS):

_____

_____

_____

_____

Are you a smoker? No/Yes (If yes please list years and packs per day):_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

Allergy/Immunology: Blistering of skin Congestion Cough Hives

Itching Rash Sneezing Wheezing Watery eyes

Unusual reaction to medication(s), food, animals or insects

General/Constitutional: Change in appetite Fever Chills Fatigue

Headache Lightheadedness Weight gain/loss

Ophthalmologic: Discharge Dry eye Itching Pain

Red eye

ENT: Decreased hearing Decreased sense of smell Difficulty swallowing

Dry mouth Ear pain Masses Nosebleed Ringing in the ears

Sinus pain Sore throat Swollen glands

Endocrine: Acne Cold intolerance Difficulty sleeping Dizziness

Excessive sweating Excessive thirst Frequent urination Hair loss

Heat intolerance Hot flashes Irregular menses

Respiratory: Chest pain Coughing up blood Pain with inspiration Sputum production

Shortness of breath at rest /or exertion

Cardiovascular: Cyanosis Palpitations Dizziness

Dyspnea on exertion Fluid in legs Irregular heartbeat

Gastrointestinal: Abdominal pain Decreased appetite Diarrhea Nausea

Difficulty swallowing Heartburn Vomiting

Musculoskeletal: Joint stiffness Leg cramps Muscle aches Painful joints

Swollen joints Weakness

Skin: Acne Discoloration Dry skin Eczema

Hair changes Sun sensitivity Rash Skin cancer

Skin oozing Scaly lesions of skin/scalp

Neurologic: Dizziness Headache Pain Seizures

Psychiatric: Anxiety Depressed mood Difficulty sleeping Stressors

Substance abuse

CANCELLATIONS/NO-SHOWS

If you are unable to keep an appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. **If you do not cancel your appointment within 24 hours of your scheduled appointment a $50.00 fee will be charged to your patient account balance.**

A "no-show" is someone who misses an appointment without canceling within 24 hours of their scheduled appointment time. Failure to present at the time of the schedule appointment will be recorded in the patient's record as a "no-show" and a $50.00 fee will be charged to your patient account balance.

When three (3) "no-show" appointments have been documented you will receive a letter from the physician discharging you from the practice.

We will offer 30 days of emergent care only and transfer your records when you find a new physician.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PATIENT REPRESENTATIVE SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____