McGOVERN ALLERGY AND ASTHMA CLINIC, P.A.

PATIENT INFORMATION SHEET

PLEASE PRINT

PATIENT NO. ______________ DATE ______________

☐ DR. ☐ MR. ☐ MRS. ☐ MISS ☐ MS.

PATIENT'S NAME LAST FIRST MIDDLE	PATIENT'S HOME PH #	BUSINESS PH #
HOME ADDRESS STREET CITY STATE ZIP	CELL PHONE #	BIRTHDATE
MAILING ADDRESS STREET CITY STATE ZIP	AGE	PATIENT'S SS # — —

RACE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HAWAIIAN OPI ☐ AMERICAN INDIAN AK NAT ☐ WHITE ☐ MEXICAN AMERICAN ☐ OTHER RACE ☐ DECLINED

PATIENT'S GENDER ☐ MALE ☐ FEMALE

ETHNICITY ☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO ☐ UNKNOWN ☐ DECLINED

MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOW/WIDOWER

LANGUAGE PREFERENCE ☐ ENGLISH ☐ FRENCH ☐ GERMAN ☐ ITALIAN ☐ JAPANESE ☐ PORTUGUESE ☐ RUSSIAN ☐ SPANISH ☐ ARABIC ☐ VIETNAMESE ☐ OTHER

OCCUPATION	PLACE OF EMPLOYMENT	E-MAIL
EMPLOYER'S ADDRESS STREET CITY STATE ZIP		CONTACT: HOW DO YOU PREFER TO BE CONTACTED: ☐ POSTAL MAIL ☐ E-MAIL ☐ HOME PHONE ☐ CELL PHONE

SPOUSE'S FULL NAME	OCCUPATION	PLACE OF EMPLOYMENT	Cell Phone No. ( ) —
ADDRESS OF SPOUSE'S EMPLOYER CITY STATE ZIP			Business Phone No. ( ) —

CHIEF PROBLEM

REFERRED BY NAME ADDRESS CITY STATE ZIP

PATIENT'S PRIMARY CARE PHYSICIAN ADDRESS CITY STATE ZIP PHONE #

PHARMACY NAME LOCATION/ADDRESS PHONE #

EMERGENCY CONTACT
NOT LIVING WITH YOU ______________ PHONE NO. ______________ RELATIONSHIP ______________

INSURANCE COMPANY		INSURED'S NAME	DATE OF BIRTH
GROUP NUMBER	POLICY NUMBER	EMPLOYER	VERIFICATION PHONE NO.

MEDICARE NO. **MEDICAID NO.**

PLEASE COMPLETE THE FOLLOWING IF PATIENT IS A MINOR OR DEPENDENT

FATHER'S FULL NAME / GUARDIAN *	DATE OF BIRTH	PLACE OF EMPLOYMENT/OCCUPATION	Business Phone No. ( ) —
HOME ADDRESS		ADDRESS	Home / Cell No. ( ) —
MOTHER'S FULL NAME / GUARDIAN *	DATE OF BIRTH	PLACE OF EMPLOYMENT/OCCUPATION	Business Phone No. ( ) —
HOME ADDRESS		ADDRESS	Home / Cell No. ( ) —

* LEGAL GUARDIAN, FOSTER PARENT, POWER OF ATTORNEY, INSTITUTIONAL REPRESENTATIVE

X ______________

SIGNATURE

McGOVERN ALLERGY and ASTHMA CLINIC, P.A. **4710 Bellaire Blvd., Ste. 200, Bellaire, TX 77401**

NAME

DATE:

PATIENT NO:

AGE:

ADDRESS:

DATE OF BIRTH:

Chief Complaint:
(Reason for coming in)

Check where applicable:

Nose/Ears/Eyes/Throat Symptoms

First noticed____________________

- ☐ Sneezing
- ☐ Runny nose

- ☐ Nasal congestion
- ☐ Nose bleeding
- ☐ Loss of smell
- ☐ Nasal polyps
- ☐ Postnasal drainage
- ☐ Frequent sore throat
- ☐ Cough
- ☐ Frequent respiratory infections
- ☐ Earaches
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Vertigo (dizziness)
- ☐ Itchy, watery eyes

Worst season____________________

Skin/Eczema

- ☐ Rash
  - ☐ red
  - ☐ swollen (raised)
  - ☐ blisters (fluid filled)
  - ☐ itchy
  - ☐ scaly, dry
  - ☐ infection

Location on body____________________

Any known cause(s)____________________

Headache Symptoms

First noticed____________________

- ☐ sharp ☐ pressure
- ☐ dull ☐ vise-like

- ☐ ____________________

Location____________________

Frequency____________________

Time headache worse__________

Any known cause(s)__________

Treatment(s) tried__________

Associated symptoms such as sinusitis

Hives and/or Swelling

- ☐ Hives

Location____________________

- ☐ Swelling

Location____________________

First noticed____________________

Duration____________________

Associated symptoms__________

Chest Symptoms

First noticed____________________

- ☐ Cough
  sputum color

- ☐ Wheeze
- ☐ Tight chest
- ☐ Attacks
  - ☐ night ☐ daytime ☐ work

Frequency of attacks__________

Last attack____________________

- ☐ Bronchitis

Worst season____________________

Insect Allergy

When stung or bitten__________

Insect____________________

Reaction(s)____________________

Treatment____________________

Latex Allergy

- ☐ Occupation related
- ☐ Contact dermatitis
- ☐ Hives
- ☐ Wheeze
- ☐ Other____________________

Precipitating Factors: (check if symptoms are worsened or affected by)

- ☐ Weather change
- ☐ Rainy days
- ☐ Foggy days
- ☐ Fumes
  (Insecticides, chemicals, tobacco smoke
- ☐ Physical exertion
- ☐ Musty odors
- ☐ Perfume or cosmetics
- ☐ House cleaning, moving
- ☐ House dust
- ☐ Mowing the lawn
- ☐ Infection
- ☐ Change of locale
- ☐ Newsprint
- ☐ Changes in temperature
- ☐ Being around animals
  What type____________________
- ☐ Playing (sitting) on grass
- ☐ Emotional stress (worries, excitement, etc)
- ☐ Other

Medications:

Allergy medications (list all past and current medications given for allergy and state which ones were helpful)

List other current (non-allergy medications)

Name____________________ Patient No.____________

Allergy History

Previous allergy tests: ☐ Yes ☐ No If so, when?__________ By whom?__________
Were allergy injections started?__________ How long were you on them?__________
Did they help you?__________

Medication allergy or intolerance (name drug and briefly describe reactions):

Food allergy (name food and briefly describe reactions present or past)

Contact allergy (poison ivy, cosmetic, leather, metal, etc.)

Environmental History:

List other places where you have lived__________
How long have you lived in your present home__________
Location (city, farm, etc.)__________
Type of heater/air conditioner__________
Pets: Indoor__________ How long have you had it__________
Outdoor__________ How long have you had it__________
Pillow type__________ with or without plastic cover__________
Mattress type__________ with or without plastic cover__________
Blanket type__________ How old is it__________
Carpet type__________ Rug type__________
Draperies type__________ Indoor plants__________
Smoker(s) ☐ yes ☐ no ☐ in home ☐ in workplace Stuffed toys in bedroom__________

Occupational Habits and Hobbies:

What type of work__________
Do you smoke__________ How long__________ How many a day__________
Did you smoke in the past__________ How long__________ When did you stop__________
Do you drink alcohol__________ How often__________
Do you use non-medicinal (recreation) drugs__________

Past Medical History: (List previous illnesses and hospitalizations, surgeries and Emergency Room visits)

Family History: (Mark with ✓ if present)

Illness	Father	Mother	Brother	Sister	Children	Other
Asthma						
Hay fever						
Sinus problems						
Hives or swelling						
Eczema						
Drug allergy						
Sinus headaches						
Migraine headaches						
Diabetes						
Rheumatic/autoimmune						
Cancer						
Immunodeficiency						

Name________________________________ Patient No.______________________

Review of Systems

Please check (✓) all items that apply and explain briefly.

General health: ☐ good ☐ bad ______________________________

Constitutional (general symptoms): ☐ fever ☐ weight loss ☐ weight gain ☐ night sweats ☐ weakness
☐ fatigue ☐ **NONE** ☐ other______________________________

Eyes: ☐ poor vision, ☐ cataracts, ☐ glaucoma, ☐ glasses, ☐ contacts (type______________________).
☐ **NONE** ☐ other______________________________

Ear, nose, throat and mouth (not noted in allergy history):
☐ pain, ☐ drainage, ☐ hearing loss ☐ vertigo (dizziness). ☐ or tinnitus (ringing). ☐ sore mouth,
☐ dental problem, ☐ **NONE** (other than allergy) ☐ other______________________________

Cardiovascular (heart and blood vessels):
☐ high blood pressure, ☐ heart attack, ☐ palpitations (and other arrhythmias). ☐ heart murmur, ☐ phlebitis.
☐ **NONE** ☐ other______________________________

Respiratory (covered in allergy section)

Gastrointestinal
☐ peptic ulcer, ☐ reflux, ☐ hepatitis, ☐ frequent vomiting, ☐ abdominal pain.
☐ frequent diarrhea, ☐ loss of appetite, ☐ chronic constipation, ☐ bleeding
☐ **NONE** ☐ other______________________________

Genitourinary: ☐ frequent urination, ☐ dysuria (pain), ☐ hematuria, ☐ nocturia (frequent night time urination),
☐ recurrent infection, ☐ sexual dysfuntion, ☐ kidney stones, ☐ menstrual problems, ☐ prostate problems
☐ **NONE** ☐ other______________________________

Musculoskeletal: ☐ joint pain, ☐ muscle pain, ☐ weakness
☐ **NONE** ☐ other______________________________

Skin (covered in allergy section)

Neurological: ☐ fainting, ☐ seizures, ☐ paralysis, ☐ headaches (other than sinus).
☐ **NONE** ☐ other______________________________

Psychiatric: ☐ depression, ☐ anxiety, ☐ insomnia, ☐ abnormal fears, ☐ mental "breakdown".
☐ **NONE** ☐ other______________________________

Endocrine: ☐ thyroid dysfunction, ☐ diabetes, ☐ adrenal dysfunction,
☐ **NONE** ☐ other______________________________

Hematologic/Lymphatic: ☐ anemia, ☐ bleeding problem, ☐ bloodborne infection;Hepatitis B/HIV.
☐ **NONE** ☐ other______________________________

Cancer ☐ type______________________________
☐ **NONE**

Allergy/Immunology (see allergy other section) ☐ immunodeficiency______________________________