

Suzanne Weakley, MD, FAAAAI, FAAAAI

Welcome to our practice! Please fill out the new patient information below to the best of your ability.

Patient name: _____ Date of Birth: _____ Race: _____

Problems you would like to discuss with Dr. Weakley today: _____

How long have you had these symptoms? _____ Which season(s) are they worse? _____

Occupation: _____ Time missed from work/school in past year: _____

Does your job cause/worsen your symptoms? Yes No How so? _____

Have you ever had an allergic reaction? Yes No To what? _____

Have you ever been allergy tested? Yes No What year? _____ By whom? _____

Have you ever taken allergy shots? Yes No For? _____ How long? _____

Medical History:

Patient Past Medical History – Have you ever had any of the following conditions?

| | | | | | |
|--------------------|-----|----|-----------------|-----|----|
| · Asthma | Yes | No | · Hives/Rash | Yes | No |
| · Bronchitis | Yes | No | · Eczema | Yes | No |
| · Hay Fever | Yes | No | · Sinusitis | Yes | No |
| · Pneumonia | Yes | No | · Migraines | Yes | No |
| · Emphysema | Yes | No | · Diabetes | Yes | No |
| · Pleurisy | Yes | No | · Heart Trouble | Yes | No |
| · Lung Cancer | Yes | No | · Hypertension | Yes | No |
| · Heartburn/Reflux | Yes | No | · Stroke | Yes | No |

Previous Hospitalizations/Surgeries/Serious Injuries? When? _____

List all current medications: _____

Do you have any drug allergies? Yes No To what? _____

Patient Social History

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Do you smoke? Yes _____ No _____

Never: _____ Previously but quit: _____ Year _____ # packs/day _____ # yrs _____

Do other members of the household smoke? Yes _____ No _____ Who? _____

Do you use other tobacco products? No _____ Yes _____ Type: _____

Excessive exposure at home or work to:

Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History – Do any of your family members or close relatives have allergy, asthma or sinus problems?

Yes No

If yes, who and what problems do they have? _____

Review of Systems – Please circle any current personal medical symptoms:

Constitutional symptoms

| | | |
|---------------------------------|-----|----|
| Good general health lately..... | Yes | No |
| Recent weight change..... | Yes | No |
| Fever..... | Yes | No |
| Fatigue..... | Yes | No |
| Headaches..... | Yes | No |

Gastrointestinal

| | | |
|-------------------------|-----|----|
| Abdominal pain..... | Yes | No |
| Peptic ulcer..... | Yes | No |
| Frequent heartburn..... | Yes | No |
| GERD (Reflux)..... | Yes | No |

Eyes

| | | |
|-------------------------------------|-----|----|
| Redness or itching..... | Yes | No |
| Eye disease or injury..... | Yes | No |
| Corrective glasses or contacts..... | Yes | No |
| Glaucoma or Cataracts..... | Yes | No |

Integumentary (skin)

| | | |
|------------------------------|-----|----|
| Rash or itching..... | Yes | No |
| Hives..... | Yes | No |
| Change in skin color..... | Yes | No |
| Change in hair or nails..... | Yes | No |

Ear/Nose/Mouth/Throat

| | | |
|---------------------------------------|-----|----|
| Hearing loss or ringing..... | Yes | No |
| Earaches, infections or drainage..... | Yes | No |
| Nose bleeds..... | Yes | No |
| Frequent nasal stuffiness..... | Yes | No |
| Runny nose..... | Yes | No |
| Postnasal drip..... | Yes | No |
| Frequent sinus infections..... | Yes | No |
| Mouth sores..... | Yes | No |
| Swollen glands in neck..... | Yes | No |

Allergic/Immunologic

Skin or other adverse reaction to:

| | | |
|-----------------------------------|-----|----|
| Penicillin or other antibiotic... | Yes | No |
| Demerol/other narcotic..... | Yes | No |
| Novocain/other anesthetic... | Yes | No |
| Aspirin/other pain remedy... | Yes | No |
| Tetanus/antitoxin/other serum... | Yes | No |
| Iodine/methiolate/antiseptic... | Yes | No |
| Other drugs/medications..... | Yes | No |
| Known food allergies..... | Yes | No |
| Environmental allergies..... | Yes | No |

Cardiovascular

| | | |
|--------------------------------------|-----|----|
| Heart trouble..... | Yes | No |
| Chest pain or angina pectoris..... | Yes | No |
| Palpitations..... | Yes | No |
| Short of breath when walking..... | Yes | No |
| Short of breath when lying flat... | Yes | No |
| Swelling of feet, ankles or hands... | Yes | No |

Neurological

| | | |
|------------------------------------|-----|----|
| Frequent/recurring headaches.... | Yes | No |
| Light-headedness or dizziness... | Yes | No |
| Numbness or tingling sensations... | Yes | No |
| Convulsions or seizures..... | Yes | No |
| Head injury..... | Yes | No |

Respiratory

| | | |
|----------------------------------|-----|----|
| Chronic or frequent coughs..... | Yes | No |
| Asthma..... | Yes | No |
| Shortness or breath..... | Yes | No |
| Wheezing or chest tightness..... | Yes | No |

Endocrine

| | | |
|----------------------------------|-----|----|
| Thyroid disease..... | Yes | No |
| Glandular/hormone problem... | Yes | No |
| Heat or cold intolerance..... | Yes | No |
| Excessive thirst or urination... | Yes | No |

Which of the following factors worsen your symptoms? Mark C for coughing, W for wheezing, S for shortness of breath, N for nasal symptoms, R for rash, H for hives (note all symptoms that apply):

Exercise: _____ Smoke: _____ Cold: _____ Alcohol: _____ Foods: _____
 Dust: _____ Irritants: _____ Dampness: _____ Stress: _____ Cosmetics: _____
 Pets: _____ Drugs: _____ Colds/flu: _____ Insect bites: _____
 Weather change: _____ Humidity: _____

Are your symptoms worse during the day _____ or night _____ or both _____?

Do your symptoms wake you at night? Yes _____ No _____ At a specific time? _____

Number of infections in the last two years:

Sinus: _____ Ear: _____ Chest: _____ Upper respiratory: _____ Throat: _____

Reviewed by: _____ Date: _____