

**Northern Colorado Allergy & Asthma Clinic, LLC
New Patient Medical Information**

Name:		<input type="checkbox"/> M <input type="checkbox"/> F	DATE:					
Primary symptom for this visit:								
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers								
Name the Drug		Strength	Frequency Taken					
Allergies to medications or foods								
Name the Drug or Food		Reaction You Had						
List medical problems that other doctors have diagnosed								
Hospitalizations or ER visits other than surgical								
Year	Reason		Hospital					
Past Allergy Therapy								
Year	Testing		Immunotherapy:	# years				
Year	Medication Tried/Failed		Alternative Therapy:					
Surgeries								
Year	Reason		Hospital					
FAMILY HEALTH HISTORY								
AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS		
Father			Children	<input type="checkbox"/> M				
Mother				<input type="checkbox"/> F				
Siblings	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F				
HEALTH HABITS AND PERSONAL SAFETY								
Alcohol	Do you drink alcohol?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?							
	How many drinks per week?							
Drugs	Do you currently use recreational or street drugs?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day		<input type="checkbox"/> Pipe - #/day		<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	Second Hand Smoke		<input type="checkbox"/> Yes	<input type="checkbox"/> No		

**Northern Colorado Allergy & Asthma Clinic, LLC
New Patient Medical Information**

REVIEW OF SYSTEMS:

Allergic/Immunologic

History of adverse reaction to:

Penicillin or other antibiotic	YES	NO
Morphine, Demerol, narcotics	YES	NO
Novacaine or other anesthetics	YES	NO
Aspirin or other pain remedies	YES	NO
Tetanus antitoxin, other vaccines	YES	NO
Milk, egg, peanut, seafood, other foods	YES	NO
Latex	YES	NO
Insect stings	YES	NO
Cat, Dog, Horse, Feathers	YES	NO

General Health

General health OK?	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

Eyes

Eye Disease or injury	YES	NO
Wear glasses or contacts	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

Ears/Nose/Mouth/Throat

Hearing Loss or ringing in ears	YES	NO
Earache or drainage	YES	NO
Chronic sinus problems or runny nose	YES	NO
Nose bleeds	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste in mouth	YES	NO
Sore throat or voice changes	YES	NO
Swollen glands in neck	YES	NO
Snoring or sleep apnea	YES	NO

Cardiovascular

Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitations	YES	NO
Shortness of breath while walking or lying flat	YES	NO
Swelling of feet, ankles or hands	YES	NO

Respiratory

Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

Gastrointestinal

Loss of Appetite	YES	NO
Change in bowel movements	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movements or constipation	YES	NO
Rectal bleeding or blood in stool	YES	NO
Abdominal pain or heartburn	YES	NO
Peptic ulcer (stomach or duodenal)	YES	NO

Dermatology

Hives	YES	NO
Eczema	YES	NO
Rash	YES	NO
Itching	YES	NO
Dryness	YES	NO
Suspicious lesion	YES	NO
Sun Sensitivity	YES	NO
Nodules/bumps	YES	NO
Hair loss	YES	NO
Psoriasis	YES	NO

Musculoskeletal

Joint Pain	YES	NO
Joint Stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back Pain	YES	NO
Cold extremities	YES	NO
Difficulty walking	YES	NO

Neurological

Frequent or recurring headaches	YES	NO
Light headedness or dizzy	YES	NO
Convulsions or seizures	YES	NO
Numbness or tingling sensations	YES	NO
Tremors	YES	NO
Paralysis	YES	NO
Stroke	YES	NO
Head injury	YES	NO

Psychiatric

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Insomnia	YES	NO

Endocrine

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes	YES	NO
Heat or cold intolerance	YES	NO

Hematological/Lymphatic

Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO
Enlarged glands	YES	NO

Genitourinary

Frequent Urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in strain while urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO