# Northeast Allergy, Asthma & Immunology

**New Patient Information**

**Patient Name: ___________________________**

**Reason for visit today**:
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________

**Other Medical History for the patient: (Review of Systems)**
*Circle* any of the following problems the patient may have (no family members)? ***PLEASE CIRCLE 'none'*** if applicable:

**General**: fevers, fatigue, weight loss, feeling cold or hot when others are comfortable, none
**Eyes**: Itchy, red eyes, cataracts, eye infections, none
**Ears**: Recurrent ear infections, hearing loss, none
**Nose**: Hay fever, sinus infections, chronic sinus pressure, stuffy nose, inability to smell, itchy nose, runny nose, none
**Throat**: Recurrent strep throat, sore throat, post nasal drip, tonsillitis, none
**Chest**: Chronic cough, wheeze, recurrent pneumonia, COPD, asthma, chest pain, none
**Heart**: Abnormal rhythm, palpitations, high blood pressure, heart disease, coronary artery disease, none
**Gastrointestinal**: Stomach pain, acid reflux, heartburn, ulcers, vomiting, diarrhea, constipation, blood in the stool, none
**Skin:** eczema, hives, swelling, psoriasis, other rashes, none
**Endocrine**: Diabetes, growth problems, thyroid problem, none
**Genitourinary**: Recurrent urinary tract infections, renal disease, prostate problems, none
**Musculoskeletal**: Arthritis, swollen joints, Lyme disease, none
**Neuro**: ADHD, Developmental Delay, seizures, migraine, none
**Lymphatics:** Swollen lymph nodes, none
**Hematologic**: Anemia, Sickle cell, none
**Psychiatric**: Depression, Anxiety, other:________________

**Hospitalizations**:_________________________________
________________________________________________
________________________________________________
________________________________________________

**Surgeries**:_______________________________________
________________________________________________
________________________________________________
________________________________________________

**Medications Allergies**:
________________________________________________
________________________________________________
________________________________________________

**Current Medications**:
Daily:
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________

As Needed:
________________________________________________
________________________________________________
________________________________________________

Medications that did not work for your problem in the past:
________________________________________________
________________________________________________
________________________________________________
________________________________________________

**Family History:**
Please circle any of the following if the patient's sisters or brothers, or parents, grandparents, cousins have them:

| | | |
|---|---|---|
| Asthma | Seasonal allergies | Indoor allergies |
| Eczema | Food allergies | Hives |
| Thyroid disease | Lupus | Immune defect |
| Heart disease | COPD | Other: |

**Home Environment**: (*please circle* any that apply)
Do you live in a house or apartment?
Do you have:
Carpeting in the house/ bedroom?
Dust mite encasements on bed? Yes/No
Stuffed animals on the patient's bed?
Any feather bedding on the patient's bed?
Are there any pets? If so what?___________________
Heating type:
Radiators; Forced hot air (comes in through vents); base-board heating; wood burning stove
Air conditioning: Central, window units, none
Any problems with: mice, roaches, mold, none
Does anyone smoke at home?__________________
For adult patients: Have you ever smoked? Yes/ No
If so, how much? _____ packs per day, _____years