AAHCHOO, PLLC

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NEW PATIENT INFORMATION

We will provide you the most advanced evidence-based medical care. For the complete Allergy Diagnostic Exam, please be prepared to spend from 1-2 hrs at your initial visit. Please refrain from taking any antihistamines (over the counter or prescription; oral,nasal,or ocular) for 7 days prior to your appointment. Please arrive for your first appointment at least 15 minutes prior to your scheduled visit.

Please bring all medications or have a written list of all current prescription or OTC medication that you are taking. Please bring reports of any x-rays of your chest or sinuses that you have had within the last year.

If we are a provider for your medical insurance, we will accept assignment of your medical benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You will be held responsible for any non-covered service that your insurance states is the patient's responsibility. We accept cash, checks, Mastercard, Discover or Visa.

All medical records are the property of AAHCHOO, PLLC. You may request copies of your records at any time. It may take up to 3 working days to fulfill your request and there will be a charge for this service.

Please give us 24 hours advance notice if you need to reschedule your appointment.

Thank you for allowing us to participate in your medical care.

Personal Information Sheet

****REMINDER: No Antihistamines or Reflux Medications for 7 days prior to your New Patient Appointment.****

Name: _____

Briefly describe the reason for your visit today? _____

_____

_____

How did you hear about our practice? ☐ Physician: _____ ☐ Friend: _____

☐ Insurance Co. ☐ Ad ☐ Internet: _____ ☐ Other: _____

Social History- Please answer the following questions regarding your social/occupational status:

1. Do you currently smoke? YES ☐ NO ☐ If yes, how long? _____
2. Do you live with someone that smokes? YES ☐ NO ☐ If yes, how long? _____
3. Do you have a history of smoking in the past? YES ☐ NO ☐ If yes, how long? _____
4. Please list all pets you currently own: _____ Are they indoor pets? YES ☐ NO ☐
5. Are you exposed to mold/fumes/strong odors/chemicals? YES ☐ NO ☐ Where/What? _____

Past Medical History- Please list all past medical problems **(Do not include active/current problems):**

1. _____ 3. _____
2. _____ 4. _____

Allergy History- Are you allergic to any **food**, **medicine**, **chemical**, **latex** or **insects**? YES ☐ NO ☐

If yes, please list: _____

Birth History- Please answer the following questions regarding the patient's birth:

1. Please circle if your birth was: On Time or Premature If premature, how many weeks? _____
2. Please list any other complications you experienced during delivery or after birth: _____

Past Surgical History- Please list all past surgeries and the date that they were performed:

1. _____ 3. _____
2. _____ 4. _____

Family History- Please list medical problems experienced by your family members: (Include allergy/asthma related problems)

1. Mother: _____ 3. Sister _____
2. Father: _____ 4. Brother: _____

Review of Systems- **Please circle** any signs/symptoms/conditions that you **currently** experience:

Constitutional:	fatigue	night sweats	chills	fevers	
Respiratory:	short of breath	wheeze	cough	croup	tight chest
GI:	heartburn	reflux	vomiting	diarrhea	trouble swallowing
Urinary:	urinary infection	blood in urine	back pain		
Frequent infections:	sinusitis	pneumonia	ear/throat	bronchitis	skin
Musculoskeletal:	stiff/sore joints	muscle pain	red/swollen joints		
Eyes:	blurry	itch	water	red	frequent infections
Nose:	runny	stuffy	itch	sneeze	loss of smell
Chest:	slow heart rate	palpitations	tight chest	chest pain	fast heart rate
Neuro:	numbness	seizures			
Skin:	dry	itch	swelling	rash	hives
Hematology:	unusual bleeding	unusual bruising	swollen lymph nodes		
Endocrine:	weight gain	weight loss	increased thirst	cold intolerance	heat intolerance
Psychology:	anxious	depressed	stressed	worried	

Current Medical Problems- Please list all current medical problems: **(Do not include resolved problems from your past)**

1. _____ 3. _____
2. _____ 4. _____

Current Medication- Please list all current OTC and **prescription medicines**, herbal remedies: **(include DOSE & DIRECTIONS)**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____