New Patient History & Physical

Mr. Miss. Ms. Mrs. Dr. Child. **Patient Name: Last**			**First** **Initial**
Date:	**Gender: M, F**	**Age:**	**Completed By: Self, Mother, Father, Other** _____

PLEASE LIST, IN ORDER OF IMPORTANCE, THE PROBLEMS THAT CONCERN YOU.

_____

_____

_____

_____

Do you have any fever today?

PLEASE LEAVE BLANK

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For patients 18 years old or younger, please fill out this paragraph. Patients over 18 years old, please skip to the next paragraph.

Birth Weight _____; length of pregnancy _____weeks; were there any complications?_____

_____

Breast and/or bottle fed? (circle) If given formula, What brand was given? _____

Feeding problems? Yes No If yes, with what foods?_____

If there a history of eczema, poor weight gain, excessive colic? (Please circle if applicable.)

Have you ever had an allergy evaluation(s)? Yes No

If yes, please circle type of test: skin test vs. blood test

Approximate year(s) of test: _____

The doctor's name(s) performing the test: _____

Circle positive test results (e.g. grass, weed, tree, mold, dust mite, cat, dog, foods, insects, etc.)

Were you tried on allergy shots? Yes No

If yes, please give approximate start and stop dates: _____

Did the allergy shots help? Yes No N/A

In your experience, please circle or list things known or suspected to cause your symptoms.

Colds / Infections	Smog	Home	Santa Ana Winds
Cold Air	Perfumes / Odors	Work	Exercise
Foods	Outdoors	Weather Change	Dust
Grass	Indoors	Pets (animal dander)	Other_____

Seasonal - Circle worst months (J F M A M J J A S O N D) _____

Please note number of courses of antibiotics used in the last 12 months. _____ If applicable, list the main reasons antibiotics were used _____

Patient Name: _____

Have any trouble with your nose? Yes No
Note approximate date of onset of nasal problems: _____

1. Seasonal	Yes	No	Don't Know
2. Year Round	Yes	No	Don't Know
3. Clear / Colorless Discharge	Yes	No	Don't Know
4. Thick / Colored Discharge	Yes	No	Don't Know
5. Sneezing	Yes	No	Don't Know
6. Itching	Yes	No	Don't Know
7. Stuffiness	Yes	No	Don't Know
8. Bleeding	Yes	No	Don't Know
9. Loss of Sense of Smell	Yes	No	Don't Know
10. Mouth Breathing	Yes	No	Don't Know
11. Snoring	Yes	No	Don't Know
12. Broken Nose	Yes	No	Don't Know
13. Nose Surgery	Yes	No	Don't Know
14. Frequent use of nasal sprays	Yes	No	Don't Know

If yes, what type?_____

Have any trouble with your ears? Yes No
Note approximate date of onset of ears problems:_____

1. Ear Infection	Yes	No	Don't Know
2. Ear Fluid	Yes	No	Don't Know
3. Ringing	Yes	No	Don't Know
4. Popping	Yes	No	Don't Know
5. Deafness	Yes	No	Don't Know
6. Itching	Yes	No	Don't Know
7. Pain	Yes	No	Don't Know
8. Tubes or Drains Placed in Ears	Yes	No	Don't Know

Please Note Date Place: _____

Have any trouble with your sinuses? Yes No
Note approximate date of onset of sinuses problems: _____

1. Fullness Over Forehead	Yes	No	Don't Know
2. Fullness Over Cheeks	Yes	No	Don't Know
3. Pain?	Yes	No	Don't Know

If so, where? _____

4. Nasal Polyps Noted	Yes	No	Don't Know
5. Sinus X - Rays Done?	Yes	No	Don't Know

Please Note Date _____ and Result _____
CAT Scan of Sinuses Done? Yes No Don't Know

Please Note Date _____ and Result _____

6. Sinus Surgery? Yes No Don't Know
Please Note Date: _____
Surgeon's Name: _____
Extent of Surgery: _____

Have any trouble with your eyes? Yes No
Note approximate date of onset of eyes problems: _____

1. Seasonal	Yes	No	Don't Know
2. Year Round	Yes	No	Don't Know
3. Dark Circles	Yes	No	Don't Know
4. Tearing	Yes	No	Don't Know
5. Redness	Yes	No	Don't Know
6. Itching	Yes	No	Don't Know
7. Puffiness	Yes	No	Don't Know
8. Wear Contact Lenses?	Yes	No	Don't Know

Have any trouble with your throat? Yes No
Note approximate date of onset of throat problems: _____

1. Sore Throat	Yes	No	Don't Know
2. Tonsillitis	Yes	No	Don't Know
3. Itching	Yes	No	Don't Know
4. Post Nasal Drip	Yes	No	Don't Know
5. Hoarseness	Yes	No	Don't Know

Have any trouble with your chest? Yes No
Note approximate date of onset of chest problems: _____

1. Wheezing	Yes	No	Don't Know
2. Morning Cough	Yes	No	Don't Know
3. Night Cough	Yes	No	Don't Know
4. Dry tight Cough	Yes	No	Don't Know
5. Deep productive Cough	Yes	No	Don't Know
6. Cough On Exertion	Yes	No	Don't Know
7. Excessive Cough With Colds	Yes	No	Don't Know
8. Chest Pain	Yes	No	Don't Know
9. Croup	Yes	No	Don't Know
10. Pneumonia	Yes	No	Don't Know
11. Bronchitis	Yes	No	Don't Know
12. Chest x - ray taken?	Yes	No	Don't Know

If yes, please note date _____ and result_____

13. Prednisone / Cortisone Use? Yes No Don't Know
If yes, please note the number of courses of prednisone in the last 12 months _____
14. Have Asthma Medications Been Tried? Yes No
Please note medication(s) tried: _____

_____

Were they helpful? Yes No
15. Do you use a spacer with your inhaler medication? Yes No If yes, what type, Inspirease, Aerochamber, other _____
16. Do you have a peak flow meter? Yes No
17. Do you use it? Yes No
18. Have you had a TB Skin Test? Yes No
Date of most recent TB Skin Test: _____
Result: _____
19. List Other Chest Problems: _____

Patient Name: _____

Have any trouble with your skin? Yes No
Note approximate date of onset of skin
Problems: _____

1. Eczema	Yes	No	Don't Know
2. Hives	Yes	No	Don't Know
3. Contact Dermatitis	Yes	No	Don't Know
4. Other Skin Problem	Yes	No	Don't Know

If yes, please list, _____

Have any trouble with your central nervous system? Yes No
Please note approximate date of onset of any of these problems: _____

1. Headaches	Yes	No	Don't Know

a. Location - Forehead, cheeks, temples, neck
b. Duration - (Hours per day) _____
c. Frequency - (Average # of headache per week) ____
d. Intensity: Mild moderate severe (circle)

2. Fatigue	Yes	No	Don't Know
3. Depression	Yes	No	Don't Know
4. Dizziness	Yes	No	Don't Know

Have any problems with your heart?

1. High Blood Pressure	Yes	No	Don't Know
2. Heart Murmur	Yes	No	Don't Know
3. Other Problem	Yes	No	Don't Know

If yes, please list _____

Have any problems with your hormones?

1. Diabetes	Yes	No	Don't Know
2. Thyroid Disorder	Yes	No	Don't Know
3. Other Hormone Problems	Yes	No	Don't Know

If yes, please list _____

WORK ENVIRONMENT:

1. What is your occupation _____
2. List any unusual exposure to chemicals or allergy triggers at work:

For Children: (Please circle)
Day Care Pre-School
Babysitter in / out of home

ACTIVITIES / HABITS:

1. Hobbies: List _____ _____ _____
2. Smoking History: Yes No
   If yes, please note year started smoking and year stopped (if applicable), also note approximate average number of packs per day (e.g. ½ p/p/d)
   _____
3. Drinking Habits: Note average consumption per week
   _____

Do you have any problem with your

GASTROINTESTINAL:

Gastrointestinal Tract?	**Yes**	**No**	
1. Chronic Diarrhea	Yes	No	Don't Know
2. Chronic Constipation	Yes	No	Don't Know
3. Liver Disease	Yes	No	Don't Know
4. Abdominal Pain	Yes	No	Don't Know
5. Heartburn	Yes	No	Don't Know
6. Hiatal Hernia	Yes	No	Don't Know
7. Poor Appetite	Yes	No	Don't Know
8. Vomiting	Yes	No	Don't Know
9. Nausea	Yes	No	Don't Know
10. Bloating	Yes	No	Don't Know
11. Colic	Yes	No	Don't Know
12. Food Avoidance	Yes	No	Don't Know

If yes, list _____

13. Special Diet	Yes	No	Don't Know

All other systems negative? Yes No
Have other medical problems? Yes No
If yes, please list any other problems:
_____
_____
_____

HOME ENVIRONMENT: PLEASE CIRCLE

1. Bed Type: standard, (age ___) waterbed, other _____.
   Does bed have allergy proof encasing? Yes No
2. Pillow Type: feather, foam, polyester _____.
   Does pillow have allergy proof encasing? Yes No
3. Flooring in bedroom: carpet, (age ___) hardwood, tile, linoleum, other _____.
4. Pets Yes No Please list type and number of pets. _____ Also please circle the pets that are allowed inside
5. Smoke Exposure Yes No
   If yes, describe _____
6. Water Damage or Moldy Odor Yes No
   If yes, describe _____
7. Air Conditioning Yes No
   Window Unit vs. Central
8. Heat - Forced Air vs. Wall Unit (circle)
9. Air Purifier Yes No Room vs. Central (circle)
10. Anything unusual about home area? Yes No
    If yes, please list: _____
11. Number of inhabitants at home: _____
12. Have you lived out of Southern California in past?
    Yes No If yes, please list where?_____
13. Apartment vs. House (circle) Age of building _____
14. How long have you lived in your current home? ____
15. Tree or grass types around home _____
16. Around your home do you have trees, grass, riverbed, park, ponds, golf course, open field? (circle)

Patient Name: _____

◊ FAMILY HISTORY:

	Please list age and any diseases that affects the immediate family
1. Father	
2. Mother	
3. Sibling	
4. Children	

◊ LIST YOUR CURRENT OR RECENT MEDICATIONS:

Medication	Strength	Frequency

HOSPITALIZATIONS:

	Age	Year	Hospital	Diagnosis / Operation	No. of Days
1					
2					
3					
4					
5					
6					

EMERGENCY ROOM VISITS (PAST TWO YEARS)

	Date	Hospital	Diagnosis
1			
2			
3			
4			
5			

PLEASE LIST KNOWN ALLERGIES TO:
(If possible note type of allergic reaction and year it occurred.)
Drugs - Including Aspirin

Foods Allergies Yes No

Insects Allergies Yes No

PLEASE LIST YOUR CURRENT
Doctor's Name: _____
Address: _____
_____

+ Would you like a report sent to your current doctor?
Yes No

+ Would you like a report sent to other physician?
Yes No If yes, please list doctors name and address
_____
_____

PLEASE LEAVE BLANK

PHYSICAL EXAMINATION:

HT.____ inches (____%) WT.____ lbs (____%) BP._____ RESP. _____ PULSE_____ TEMP. _____°F PEFR ____

GEN: WDWN in NAD other
EYES: Conjunctivae: Normal Injected Shiners
NOSE: Septum: Midline or Deviated Nasal Crease
Turbinates: Size: Small Moderate Large
Color: Pink Pale Injected Crusted
Mucus: Clear Cloudy Polyps
Ears TMs: Normal Dull Injected

THROAT: Normal Injected
NECK: Supple/No Adenopathy
CHEST: Clear to Ausculation Wheeze Rhonchi
COR: Regular rate/ rhythm, S1, S2, S3, S4, Murmur _____
SKIN: Normal Other _____
ABDOMEN: Soft, Nontender, Nondistended,
Normal Bowel Sounds, Masses _____