McGOVERN ALLERGY AND ASTHMA CLINIC, P.A.

PATIENT INFORMATION SHEET

PLEASE PRINT

PATIENT NO. _____ DATE _____

☐ DR. ☐ MR. ☐ MRS. ☐ MISS ☐ MS.

PATIENT'S NAME LAST	FIRST	MIDDLE	PATIENT'S HOME PH #	BUSINESS PH #

HOME ADDRESS STREET	CITY	STATE	ZIP	CELL PHONE #	BIRTHDATE

MAILING ADDRESS STREET	CITY	STATE	ZIP	AGE	PATIENT'S SS #
					– –

RACE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HAWAIIAN OPI ☐ AMERICAN INDIAN AK NAT ☐ WHITE ☐ MEXICAN AMERICAN ☐ OTHER RACE ☐ DECLINED

PATIENT'S GENDER ☐ MALE ☐ FEMALE

ETHNICITY ☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO ☐ UNKNOWN ☐ DECLINED

MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOW/WIDOWER

LANGUAGE PREFERENCE ☐ ENGLISH ☐ FRENCH ☐ GERMAN ☐ ITALIAN ☐ JAPANESE ☐ PORTUGUESE ☐ RUSSIAN ☐ SPANISH ☐ ARABIC ☐ VIETNAMESE ☐ OTHER

OCCUPATION	PLACE OF EMPLOYMENT	E-MAIL

EMPLOYER'S ADDRESS STREET CITY STATE ZIP

CONTACT: HOW DO YOU PREFER TO BE CONTACTED: ☐ POSTAL MAIL ☐ E-MAIL ☐ HOME PHONE ☐ CELL PHONE

SPOUSE'S FULL NAME	OCCUPATION	PLACE OF EMPLOYMENT	Cell Phone No.
			( ) –

ADDRESS OF SPOUSE'S EMPLOYER CITY STATE ZIP — Business Phone No. ( ) –

CHIEF PROBLEM

REFERRED BY NAME ADDRESS CITY STATE ZIP

PATIENT'S PRIMARY CARE PHYSICIAN ADDRESS CITY STATE ZIP PHONE #

PHARMACY NAME LOCATION/ADDRESS PHONE #

EMERGENCY CONTACT
NOT LIVING WITH YOU _____ PHONE NO. _____ RELATIONSHIP _____

INSURANCE COMPANY		INSURED'S NAME	DATE OF BIRTH
GROUP NUMBER	POLICY NUMBER	EMPLOYER	VERIFICATION PHONE NO.

MEDICARE NO.	**MEDICAID NO.**

PLEASE COMPLETE THE FOLLOWING IF PATIENT IS A MINOR OR DEPENDENT

FATHER'S FULL NAME / GUARDIAN *	DATE OF BIRTH	PLACE OF EMPLOYMENT/OCCUPATION	Business Phone No.
			( ) –
HOME ADDRESS		ADDRESS	Home / Cell No.
			( ) –
MOTHER'S FULL NAME / GUARDIAN *	DATE OF BIRTH	PLACE OF EMPLOYMENT/OCCUPATION	Business Phone No.
			( ) –
HOME ADDRESS		ADDRESS	Home / Cell No.
			( ) –

* LEGAL GUARDIAN, FOSTER PARENT, POWER OF ATTORNEY, INSTITUTIONAL REPRESENTATIVE

X _____
SIGNATURE

McGOVERN ALLERGY and ASTHMA CLINIC, P.A. 4710 Bellaire Blvd., Ste. 200, Bellaire, TX 77401

NAME DATE

PATIENT NO AGE

ADDRESS DATE OF BIRTH

Chief Complaint
(Reason for coming in)

Check where applicable:

Nose/Ears/Eyes/Throat Symptoms

First noticed_____
☐ Sneezing
☐ Runny nose

☐ Nasal congestion
☐ Nose bleeding
☐ Loss of smell
☐ Nasal polyps
☐ Postnasal drainage
☐ Frequent sore throat
☐ Cough
☐ Frequent respiratory infections
☐ Earaches
☐ Ear infections
☐ Hearing loss
☐ Vertigo (dizziness)
☐ Itchy, watery eyes
Worst season_____

Skin/Eczema

☐ Rash
- ☐ red
- ☐ swollen (raised)
- ☐ blisters (fluid filled)
- ☐ itchy
- ☐ scaly, dry
- ☐ infection

Location on body_____
_____
Any known cause(s)_____
_____

Headache Symptoms

First noticed_____
☐ sharp ☐ pressure
☐ dull ☐ vise-like

☐ _____
Location_____
Frequency_____
Time headache worse_____
Any known cause(s)_____
_____
_____
Treatment(s) tried_____
_____
Associated symptoms such as sinusitis
_____

Hives and/or Swelling

☐ Hives
Location_____
☐ Swelling
Location_____
First noticed_____
_____
_____
Duration_____
_____
_____
_____
Associated symptoms_____
_____
_____

Chest Symptoms

First noticed_____
☐ Cough
sputum color

☐ Wheeze
☐ Tight chest
☐ Attacks
☐ night ☐ daytime ☐ work
Frequency of attacks_____
_____
Last attack_____
☐ Bronchitis
Worst season_____

Insect Allergy

When stung or bitten_____
Insect_____
Reaction(s)_____
_____
_____
Treatment_____
_____
_____

Latex Allergy

☐ Occupation related
☐ Contact dermatitis
☐ Hives
☐ Wheeze
☐ Other_____
_____

Precipitating Factors: (check if symptoms are worsened or affected by)

☐ Weather change
☐ Rainy days
☐ Foggy days
☐ Fumes
(Insecticides, chemicals, tobacco smoke
☐ Physical exertion
☐ Musty odors
☐ Perfume or cosmetics
☐ House cleaning, moving
☐ House dust
☐ Mowing the lawn
☐ Infection
☐ Change of locale
☐ Newsprint
☐ Changes in temperature
☐ Being around animals
What type_____
☐ Playing (sitting) on grass
☐ Emotional stress (worries, excitement, etc)
☐ Other

Medications:

Allergy medications (list all past and current medications given for allergy and state which ones were helpful)

List other current (non-allergy medications)

Name_____ Patient No._____

Allergy History

Previous allergy tests: ☐ Yes ☐ No If so, when?_____ By whom?_____
Were allergy injections started?_____ How long were you on them?_____
Did they help you?_____

Medication allergy or intolerance (name drug and briefly describe reactions):

Food allergy (name food and briefly describe reactions present or past)

Contact allergy (poison ivy, cosmetic, leather, metal, etc.)

Environmental History:

List other places where you have lived_____
How long have you lived in your present home_____
Location (city, farm, etc.)_____
Type of heater/air conditioner_____
Pets: Indoor_____ How long have you had it_____
Outdoor_____ How long have you had it_____
Pillow type_____ with or without plastic cover_____
Mattress type_____ with or without plastic cover_____
Blanket type_____ How old is it_____
Carpet type_____ Rug type_____
Draperies type_____ Indoor plants_____
Smoker(s) ☐ yes ☐ no ☐ in home ☐ in workplace Stuffed toys in bedroom_____

Occupational Habits and Hobbies:

What type of work_____
Do you smoke_____ How long_____ How many a day_____
Did you smoke in the past_____ How long_____ When did you stop_____
Do you drink alcohol_____ How often_____
Do you use non-medicinal (recreation) drugs_____

Past Medical History: (List previous illnesses and hospitalizations, surgeries and Emergency Room visits)

Family History: (Mark with ✓ if present)

Illness	Father	Mother	Brother	Sister	Children	Other
Asthma						
Hay fever						
Sinus problems						
Hives or swelling						
Eczema						
Drug allergy						
Sinus headaches						
Migraine headaches						
Diabetes						
Rheumatic/autoimmune						
Cancer						
Immunodeficiency						

Name_____ Patient No._____

Review of Systems

Please check (✓) all items that apply and explain briefly.

General health: ☐ good ☐ bad _____

Constitutional (general symptoms): ☐ fever ☐ weight loss ☐ weight gain ☐ night sweats ☐ weakness
☐ fatigue ☐ **NONE** ☐ other_____

Eyes: ☐ poor vision, ☐ cataracts, ☐ glaucoma, ☐ glasses, ☐ contacts (type_____)
☐ **NONE** ☐ other_____

Ear, nose, throat and mouth (not noted in allergy history):
☐ pain, ☐ drainage, ☐ hearing loss ☐ vertigo (dizziness). ☐ or tinnitus (ringing). ☐ sore mouth,
☐ dental problem, ☐ **NONE** (other than allergy) ☐ other_____

Cardiovascular (heart and blood vessels):
☐ high blood pressure, ☐ heart attack, ☐ palpitations (and other arrhythmias). ☐ heart murmur, ☐ phlebitis.
☐ **NONE** ☐ other_____

Respiratory (covered in allergy section)

Gastrointestinal
☐ peptic ulcer, ☐ reflux, ☐ hepatitis, ☐ frequent vomiting, ☐ abdominal pain.
☐ frequent diarrhea, ☐ loss of appetite, ☐ chronic constipation, ☐ bleeding
☐ **NONE** ☐ other_____

Genitourinary: ☐ frequent urination, ☐ dysuria (pain), ☐ hematuria, ☐ nocturia (frequent night time urination),
☐ recurrent infection, ☐ sexual dysfuntion, ☐ kidney stones, ☐ menstrual problems, ☐ prostate problems
☐ **NONE** ☐ other_____

Musculoskeletal: ☐ joint pain, ☐ muscle pain, ☐ weakness
☐ **NONE** ☐ other_____

Skin (covered in allergy section)

Neurological: ☐ fainting, ☐ seizures, ☐ paralysis, ☐ headaches (other than sinus).
☐ **NONE** ☐ other_____

Psychiatric: ☐ depression, ☐ anxiety, ☐ insomnia, ☐ abnormal fears, ☐ mental "breakdown".
☐ **NONE** ☐ other_____

Endocrine: ☐ thyroid dysfunction, ☐ diabetes, ☐ adrenal dysfunction,
☐ **NONE** ☐ other_____

Hematologic/Lymphatic: ☐ anemia, ☐ bleeding problem, ☐ bloodborne infection:Hepatitis B/HIV.
☐ **NONE** ☐ other_____

Cancer ☐ type _____
☐ **NONE**

Allergy/Immunology (see allergy other section) ☐ immunodeficiency_____