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FOR OFFICE USE:

PATIENT MEDICAL RECORD NUMBER: _____ STAFF INITIALS: _____

TODAY'S DATE: _____ APPOINTMENT DATE: _____

PATIENT'S FULL LEGAL NAME: _____ DATE OF BIRTH: _____

MALE: _____ FEMALE: _____ MARITAL STATUS: _____ ETHNICITY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

(Please circle which is preferred phone above number)

PERMISSION TO LEAVE A MESSAGE/TEXT MESSAGE? YES NO

EMAIL: _____ PATIENT'S OCCUPATION: _____

PATIENT'S EMPLOYER: _____ ADDRESS: _____

PRIMARY CARE PROVIDER : _____

ADDRESS: _____ PHONE NUMBER: _____

PHARMACY NAME: _____ PHONE NUMBER: _____

WHO CAN WE THANK FOR RECOMMENDING KENWOOD? _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT: **(NOTE: PATIENTS 18 YEARS OR OLDER ARE RESPONSIBLE FOR PAYMENT.)**

FULL LEGAL NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

RELATIONSHIP: _____ EMPLOYER: _____

STEP PARENT NAME(S): _____

****DIVORCED PARENTS: IT IS THE OFFICE POLICY THAT THE PARENT ACCOMPANYING THE CHILD WILL BE RESPONSIBLE FOR ALL BILLS**

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE NUMBER: _____

PATIENT NAME: _____ PATIENT MRN: _____

REASON FOR TODAY'S VISIT/YOUR SYMPTOMS: _____

Please circle any of the following that are problems for the patient:

Sneezing	Stuffy nose	Runny nose	Frequent sinus infections	Throat clearing
Hoarseness	Watery eyes	Red eyes	Itchy eyes	Hives
Eczema	Skin Itching	Lip swelling	Facial swelling	Wheezing
Cough	Shortness of breath	Chest tightness	Food reactions	Drug reactions

Food reactions (what food and what type of reaction): _____

Drug reactions (which drugs and what type of reaction): _____

Insect reactions (which insect and what type of reaction): _____

Previous allergy testing: Yes No If yes, when: _____

Previous allergy shots: Yes No If yes, when did you stop: _____

Previous allergist name and phone number: _____

If you have previously seen an allergist, it is requested that you bring a copy of your records to your initial appointment.

History of Illness:

When did the problems begin? _____

How often do the problems occur: (Circle all that apply)

Every day Off and On Rarely with Exercise Nighttime Morning

Spring Summer Fall Winter

Other: _____

What makes the problems worse: (Circle all that apply)

Animals Grass Mold Dust Weeds Foods Exercise

Fumes/odors Weather changes Respiratory infections

What makes it better? _____

What medications have you tried to treat your symptoms? _____

PATIENT NAME: _____ PATIENT MRN: _____

Please list ALL current medications:

Medication name	Dose	Frequency and time of day

Review of Systems & Medical History

Please circle all of the following symptoms you have had in the past or are currently experiencing.

General:	Chills	Fatigue	Fever	Night sweats
	Weight gain	Weight loss	Sleep disturbance	

Head:	Dizziness	Headache	Recurrent sinus infections	Sinus Pressure
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Ears:	Earaches	Clogged ears	Hearing Problems	Recurrent ear infections
	Ear drainage			

Eyes:	Drainage	Dry eyes	Itchy Eyes	Red eyes	Water eyes
	Dark circles	Cataracts			

Nose:	Itchy nose	Nasal congestion	Nose bleeds	Post nasal drip
	Runny nose	Sneezing	Nasal drainage	Sores in nose

PATIENT NAME: _____ PATIENT MRN: _____

Throat: Throat clearing Hoarseness Itchy throat Sore throat Throat infections
Swallowing problems

Heart: Heart disease High blood pressure Racing heart Heart palpitations

Lungs: Cough Shortness of breath Wheeze Chest tightness
Difficulty exercising Nighttime breathing problems

GI: Heartburn Abdominal pain Nausea Vomiting Constipation
Bloating Food intolerance Diarrhea

GU: Frequent urination Painful urination Kidney stones Prostate disease

Endocrine: Low blood sugar High blood sugar Hot/cold disturbance Frequent steroid use

Musculoskeletal:

Back pain Joint pain Joint swelling Neck pain Osteoporosis

Skin: Persistent itch Hives Eczema Lip swelling Facial swelling
Bruising Boils Recurrent skin infections

Neurologic: Seizure disorder Numbness Tingling Tremors Migraine Dizziness

PATIENT NAME: _____ PATIENT MRN: _____

Psychological : Anxiety Depression Mental Illness

Hematologic: Bleeding disorders Blood clotting problem Cancer

Past Medical History

Past Hospitalizations:

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Family History- Anyone in your family with the following:

- | | | | |
|----------------------|--------|-----------|-------------------------|
| Allergies: | YES NO | Relation: | _____ |
| Asthma: | YES NO | Relation: | _____ |
| High blood pressure: | YES NO | Relation: | _____ |
| Eczema: | YES NO | Relation: | _____ |
| Kidney disease | YES NO | Relation: | _____ |
| Food allergies: | YES NO | Relation: | _____ Which food: _____ |
| Thyroid disease | YES NO | Relation: | _____ |
| Hives: | YES NO | Relation: | _____ |
| Seizure disorder: | YES NO | Relation: | _____ |
| Strokes: | YES NO | Relation: | _____ |

Other chronic conditions:

PATIENT NAME: _____ PATIENT MRN: _____

Immunization History:

Childhood Immunizations Up to Date: YES NO

Last Flu Shot: _____ Last Pneumovax: _____ Last COVID: _____

Social/Environmental History

Occupation: _____

Do your symptoms change at work? Worsen Improve

Recreational Activities that are impacted by Symptoms: _____

Tobacco Exposure: Please indicate your tobacco status by circling the following:

No Tobacco Exposure Current Smoker (How much and how many years) _____

Exposed to second hand smoke Past smoker (How long ago did you quit) _____

Pets:

Dog (How many) _____ Cats (How many) _____ Other pets _____

Do pets have access to bed or bedroom: Yes No

How old is your home? _____ How long have you lived there? _____

Type of home: House Condo Apartment Mobile home

Location: Suburb City Country Near water

Type of heating: Forced air Baseboard Hot water Wood Burning Steam Oil

Type of cooling: None Central air Window unit

Air purifier: None Central Room unit

Humidifier: None Room unit Attached to furnace

Dehumidifier: No Yes (Where is it located?) _____

Any recent water damages? Yes No

Bedroom: Carpet Tile Wood flooring

Feather bedding Feather pillows Allergy covers on pillows/mattress: Yes No

Age of mattress: _____ Age of Pillows: _____ Stuffed animals in bedroom? No Yes

Provider reviewed: _____ Date: _____