The Allergy and Asthma Center of Corpus Christi
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NEW PATIENT FORMS FOR ADULT

Patient Last Name ____________________ First Name ________________ Middle Name ______________

DOB _______________________ Age _____________ Race ___________ SSN _________________

Sex _________ Single __________ Married __________ Widowed ___________ Divorced ___________

Cell phone __________________ Home phone __________________ Work phone ___________________

Address ____

City, State, Zip ____

EMAIL ____ Occupation ____________________________

Employer Name ____

Address ____

City, State, Zip ____

Spouse Name ___________________________ Social Security # ____________ DOB ___________

Cell phone ____________________ Home phone __________________ Work phone ___________________

Address (if different) ____

City, State, Zip ____

EMAIL ____ Occupation ______________________________

Employer Name ____

Address ____

Primary Insurance ___________________________ Name of Policy Holder _____________________________

Secondary Insurance __________________________ Name of Policy Holder ____________________________

****How did you hear about us?** ____

Patient Signature ____ **Date** ____________________________

HIPAA COMMUNICATION AUTHORIZATIONS

I/We authorize Allergy and Asthma Center to leave messages or discuss my PHI with the names listed below:

Contact Person ____________________ Relationship ____________________

Primary Care Doctor ____________________ Phone: ____________________

Referring Doctor ____________________ Phone: ____________________

Other Doctor ____________________ Phone: ____________________

Other Doctor ____________________ Phone: ____________________

I authorize Allergy and Asthma Center of Corpus Christi to use the following form(s) of communication when contacting me about upcoming appointments, my medical care, my prescriptions, and/or my bill with the practice. (Please set 1, 2 ……. as your priority)

☐ Text cell phone ☐ Email ☐ Call ☐ Voicemail

Contact person Email ____

Cell phone ______________________ Home phone ______________________ Work phone ______________________

Patient Signature _________________________________

Date ____________________________________

Preferred Retail Pharmacy

Pharmacy Name	
Phone Number	
Address	
Store Number	

Patient First Name_________________________ Last Name ____________________ Date of Birth ___________________

Please check any of the following **Symptoms** that you are currently experiencing or that you have had recently

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Nasal Symptoms ☐ Past ☐ Present

☐ Nasal congestion
☐ Runny nose
☐ Nasal discharge
☐ Postnasal drip
☐ Snoring
☐ Nasal itching
☐ Frequent sneezing
☐ Frequent nose bleeds
☐ Nasal polyps
☐ Loss of sense of smell
☐ Loss of sense of taste

Sinus ☐ Past ☐ Present

☐ Frequent infections
☐ Pressure in sinuses
☐ Postnasal drip
☐ Nighttime cough
☐ Sinus headaches
☐ Bad breath

How many times in the last year have you taken an antibiotic for a sinus infection? _________
Is so, when was the last time? _________
Have you ever had a sinus CT (CAT scan) or x-rays? ☐ No ☐ Yes
If yes, when was most recent one? _____
Have you ever had sinus surgery? ☐ No ☐ Yes. If yes, date: __________

Eye Symptoms ☐ Past ☐ Present

☐ Itching
☐ Watery eyes
☐ Redness or burning
☐ Swelling of eyelids

Frequent Ear Infections
☐ Past ☐ Present
Have you had pressure equalization tubes? ☐ No ☐ Yes
If yes, date(s): ______________________

Ear Symptoms ☐ Past ☐ Present

☐ Pain
Pressure
☐ Itching
☐ Loss of hearing

Headaches ☐ Past ☐ Present

☐ Sinus
☐ Tension
☐ Migraine
☐ With menses

Location of headaches
☐ Frontal
☐ Temple area
☐ Back of head
☐ One-sided

Is your headache
☐ Sharp pain
☐ Throbbing pain
☐ Dull pain

When you have headaches,
do you have nausea or vomiting? ☐ do you have difficulty with vision? ☐ are you bothered by light? ☐
are you bothered by noise? ☐

Frequency of headaches

☐ Daily
☐ Occasionally
☐ Weekly
☐ Seldom

Effective medicines for headaches (list names): __________________________

____

Lung Symptoms ☐ Past ☐ Present

☐ Asthma
☐ Wheezing
☐ Chest "colds" or congestion
☐ Chest symptoms with exercise
☐ Shortness of breath at rest
☐ Shortness of breath at night
☐ Sudden attacks of shortness of breath
☐ Pneumonia
☐ Bronchitis
☐ Bronchiolitis
☐ Croup
☐ Cough
☐ Coughing up blood

Gastrointestinal ☐ Past ☐ Present

☐ Frequent nausea or vomiting
☐ Frequent episodes of diarrhea
☐ Heartburn
☐ Regurgitation of food
☐ Acid or sour taste in your mouth in the morning
☐ Abdominal cramping
☐ Itching of mouth or throat
☐ Food allergy: list which foods

____
____
____

Skin Symptoms ☐ Past ☐ Present

☐ Hives
☐ Itching
☐ Eczema
☐ Contact ras

WHICH OF THE FOLLOWING TRIGGER FACTORS MAKE YOUR SYMPTOMS WORSE? (check all that apply)

☐ Bronchitis
☐ Colds, influenza
☐ Sinus infections
☐ Nonsteroidal antiinflammatory medicines (such as ibuprofen or naproxen)
☐ Aspirin
☐ Exercise
☐ Wines, alcoholic beverages
☐ Cigarette smoke
☐ Perfumes, hairsprays, strong odors
☐ Cold air

☐ Nighttime
☐ Weather changes
☐ Cutting grass
☐ Cats
☐ Dogs
☐ Other animals (specify)

____

☐ Foods (specify)

____
____
____

☐ Food additives (specify)

____
____
____

☐ Laughter
☐ Strong emotions or stress
☐ Menstrual cycles
☐ Damp, musty places
☐ House dusting or vacuuming
☐ Occupational exposures
☐ Air pollution

ALLERGY HISTORY

Are your symptoms: ☐ Year-round ☐ Seasonal Other ____

If seasonal, which season(s)? (check all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Which months are worse for you?

☐ January	☐ February	☐ March	☐ April
☐ May	☐ June	☐ July	☐ August
☐ September	☐ October	☐ November	☐ December

Have you had allergy skin testing? ☐ Yes ☐ No If yes, test date ____________________ by ________________________

Test results:____

____

Have you had allergy shots? ☐ Yes ☐ No If yes, started date ___________________ ended date ______________________

Did allergy shots help your symptoms? ☐ Yes ☐ No

Please list all known inhalant, food, and medicine allergies other than those detected only by skin testing:

WHAT YOU ARE ALLERGIC TO	REACTION

Do you have any other allergy problems, such as latex sensitivity or insect sting allergy (bee, wasp, yellow jacket, hornet, or fire ant)?

☐ Yes ☐ No If yes, please list: ____

____

____

USE OF MEDICATIONS

Please list all current ORAL and INHALED medications prescribed by your doctor and any nonprescription medicines you are taking:

MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN

Please list medications you have taken in the past but no longer are taking for the symptoms being evaluated here: _______________

____

____

MEDICAL HISTORY

List all hospitalizations or ☐ None

DATES OF HOSPITALIZATION	NAME OF HOSPITAL	REASON FOR HOSPITALIZATION

Please list all surgical procedures and the date they were done or ☐ None

PROCEDURE	DATE

ASTHMA SEVERITY

Have you been admitted to hospital because of asthma? ☐ No ☐ Yes. If yes, how many in the last year? ____________
Have you been admitted to an Intensive Care Unit because of asthma? ☐ No ☐ Yes. If yes, when? ____________
Have your asthma symptoms resulted in respiratory arrest, intubation or use of a mechanical ventilator? ☐ No ☐ Yes

List any previous testing you have had or ☐ None

	APPROXIMATE DATE	RESULT
☐ Chest x-ray		
☐ Sinus CT or x-ray		
☐ Sweat chloride test		
☐ Pulmonary function tests		
☐ Barium swallow		
☐ Nasopharyngoscopy or laryngoscopy		
☐ Esophagoscopy		
☐ Bronchoscopy		
☐ Immunoglobulin studies		
☐ Other ____________		
☐		

Have you had any of the following or ☐ None?

- ☐ Cataracts
- ☐ Thyroid disease
- ☐ Migraine headaches
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Elevated cholesterol
- ☐ Pneumonia
- ☐ Cancer
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Irritable bowel syndrome
- ☐ Gastroesphageal reflux
- ☐ Positive tuberculin skin test
- ☐ Osteoporosis
- ☐ Any severe infections

Other medical problems?
____
____

SOCIAL HISTORY (check all that apply)

☐ Alcohol use:______drinks per week ☐ No Alcohol use

☐ At risk for HIV infection (unprotected sex, IV drug use, history of blood transfusions)

☐ History of drug use

Smoking Status: ☐ Current If current:______packs per day

☐ Former (when quit:________________) ☐ Never smoked Second hand smoke exposure:

☐ Environmental ☐ Occupational ☐ Perinatal/before birth

☐ Tobacco use (other/chew):________________________

REVIEW OF THE SYSTEM

Please Circle 'Yes' Or 'No' For All Items Below
(Problems you have had within the past 3 months)

ALLERGY/IMMUNE
Yes No Hayfever
Yes No Swollen glands or nodes
Yes No Weak immune system

CARDIOVASCULAR
Yes No Chest pain
Yes No High blood pressure
Yes No Palpitation or heart racing
Yes No Swelling in legs or feet

EARS
Yes No Ear aches
Yes No Ear infections
Yes No Hearing problems
Yes No Tinnitus
Yes No Vertigo

ENDOCRINE
Yes No Breast discharge
Yes No Diabetes
Yes No Excessive thirst
Yes No Heat or cold intolerance
Yes No Thyroid problems

EYES
Yes No Blurry vision
Yes No Double vision
Yes No Glasses or contacts
Yes No Glaucoma

GENERAL
Yes No Fatigue
Yes No Fever
Yes No Loss of appetite
Yes No Night sweats
Yes No Recent weight change

GASTROINTESTINAL
Yes No Abdominal pain
Yes No Blood in stool
Yes No Constipation
Yes No Diarrhea
Yes No Difficulty swallowing
Yes No Heartburn
Yes No Nausea or vomiting

GENITOURINARY
Yes No Blood in urine
Yes No Frequent urination
Yes No Kidney stones
Yes No Loss of bladder control

HEMATOLOGIC/LYMPH
Yes No Anemia
Yes No Blood transfusions
Yes No Easy bruising or bleeding

INTEGUMENTARY (Skin)
Yes No Changes in hair or nails
Yes No Dryness
Yes No New stretch marks
Yes No Rashes

MOUTH and THROAT
Yes No Dry mouth
Yes No Frequent sore throats
Yes No Sore tongue

MUSCULOSKELETAL
Yes No Back pain
Yes No Muscle cramps
Yes No Muscle weakness
Yes No Neck pain
Yes No Swelling or pain in joints

NEUROLOGIC
Yes No Frequent headaches
Yes No Head injury
Yes No Loss of consciousness
Yes No Numbness around mouth
Yes No Numbness or tingling
Yes No Seizures
Yes No Tremors

NOSE and SINUSES
Yes No Frequent colds
Yes No Nasal stuffiness
Yes No Sinus troubles

PSYCHIATRIC
Yes No Anxiety
Yes No Depression

RESPIRATORY
Yes No Asthma
Yes No Frequent cough
Yes No Shortness of breath
Yes No Spitting up blood
Yes No Wheezing

Patient (or Patient) Signature ______________________________

Today's Date: ________________