The Allergy and Asthma Center of Corpus Christi
1718 Braeswood Dr, Corpus Christi TX 78412
text: 361-992-8500 Fax: 361-992-6711
www.allergycorpustx.com

NEW PATIENT FORMS FOR CHILD

Child Last Name ____________________ First Name ________________ Middle Name ______________

DOB ___________________ Age ________ Race _____________ SSN ________________________

Sex _________ Single __________ Married __________ phone _____________________ (Cell/ Home)

Physical Address ____

City, State, Zip ____

Father(Step) Name ___________________________ SSN _________________ DOB ______________

Cell phone ____________________ Home phone __________________ Work phone ____________________

Address (if different) ____

City, State, Zip ____

EMAIL ____ Occupation ______________________________

Employer Name ____

Address ____

Mother(Step) Name ___________________________ SSN _________________ 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 / Parent Signature ____**Date** ____________________

HIPAA COMMUNICATION AUTHORIZATIONS

I/We authorize Allergy and Asthma Center to leave messages or discuss my /my child's 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

My Email ____

Cell phone ______________________ Home phone ______________________ Work phone ______________________

Contact person Email ____

Cell phone ______________________ Home phone ______________________ Work phone ______________________

Patient / parent 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

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 ☐ Itching
- ☐ Pressure ☐ Loss of hearing

Headaches ☐ Past ☐ Present

- ☐ Sinus ☐ Migraine
- ☐ Tension ☐ With menses

Location of headaches

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

Is your headache

- ☐ Sharp pain ☐ Dull pain
- ☐ Throbbing 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 ☐ Weekly
- ☐ Occasionally ☐ 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	☐ Diabetes	☐ Hiatal hernia	☐ Any severe infections
☐ Thyroid disease	☐ Elevated cholesterol	☐ Irritable bowel syndrome	Other medical problems?
☐ Migraine headaches	☐ Pneumonia	☐ Gastroesphageal reflux	____________
☐ Heart disease	☐ Cancer	☐ Positive tuberculin skin test	____________
☐ High blood pressure	☐ Hepatitis	☐ Osteoporosis	

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 Parent) Signature ______________________________

Today's Date: ________________