

(Office Only) MRN: _____



Henry Yeates, MD • Tammy Jacobs, MD
Evangeline Lindorf, NP

PATIENT NAME: _____

DOB: ___/___/___ AGE: _____ SEX: M / F

Primary Care MD: _____

Referring MD: _____

Pharmacy (Name/Location): _____

Date: ___/___/___

Form completed by: Patient Parent/Guardian: _____

Main Reason for Today's Visit:

Please also check if you have any of the following conditions:

- Allergic Rhinitis/Sinusitis (Hay Fever) Asthma or Breathing Problems Food Allergies/Reactions Eosinophilic Esophagitis
- Allergic Conjunctivitis (Eye Allergy) Hives or Rash Contact Dermatitis/Rash Atopic Dermatitis (Eczema)
- Allergy/Reaction to Stinging Insects Allergy/Reaction to Latex Penicillin Allergy Frequent Infections

Medical/Surgical/Hospitalization History:

- Gastroesophageal Reflux (Heart Burn) High Blood Pressure Heart Disease Diabetes
- Sleep Apnea Osteoporosis (or osteopenia) Thyroid Disease Cancer, please detail below

Other Diagnosis/Surgery/Hospitalization	Date	Medications for Medical Condition

Current Medications (Please Include Name/Dosage/Frequency and Vitamins/Supplements/Over the Counter Medications):

Allergy History:

Medication Allergies	Reaction (such as hives, rash, swelling, vomiting, wheezing)
Other (Food, Latex, Stinging Insects)	Reaction (such as hives, rash, swelling, vomiting, wheezing)

Immunizations Up To Date: Yes No

Influenza Vaccine (this season from September to April): Yes No

If you have not received the flu shot this season, would you like it to be administered at this office visit? Yes No

Family History: Unknown Adopted

	None	Mother	Father	Sibling(s)	Grandparent(s)	Other relative, specify:
Nasal/Sinus Allergies (Seasonal Allergies/Hay Fever)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Atopic Dermatitis (Eczema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bee sting allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eosinophilic Esophagitis or Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urticaria or Angioedema (Hives or Swelling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune Disease (such as Thyroid Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune Problems or Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease (such as COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer, Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Conditions: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social/Environmental History:

Do you smoke or are you a former smoker? Yes No If yes, __ packs per day for __ years. Quit __ years ago.

Do you drink alcohol? Yes No

Do you use any drugs/medications recreationally? Yes No

Occupation or grade in school: _____ Homemaker Unemployed
 No Daycare (Stays at Home) Preschool Grade School High School College

With whom do you (does your child) primarily live: _____ Multiple Households: Yes

Pets in or around the home: None Cat(s) Dog(s) Guinea Pig(s) Bird(s) Horse(s) Other: _____

Does anyone inside the home smoke? Yes No

Is there any water damage in the home? Yes No

Is there any mold inside or outside of your home? Yes No

Are there problems with pests inside the home? Yes No If yes, specify: _____

What type of heating do you have in your home? Gas/Forced air Fireplace/Gas stove Other: _____

What type of air conditioning do you have? Swamp cooler Central air Window units None

Do you have carpeting in your home? Throughout Minimal No

Do you use feather blankets or pillows? Yes No

Any strong fragrances used in your home? Yes No

Do you (does your child) follow a special diet? Yes No

If yes, please describe: _____

Have you (or your child) traveled internationally? Yes No

If yes, when/where: _____

Review of Systems:

Please indicate any symptoms you (or your child) have experienced recently.

Constitutional: Fever Chills Fatigue Loss of appetite Weight loss Weight gain

Skin: Rash Itching Hives Dryness Frequent skin infections

Head: Headache Sinus pressure Sinus tenderness

Eyes: Itchy eyes Red eyes Burning eyes Watery eyes

Ears: Itchy ears Frequent ear infections Ear tubes

Nose: Itchy nose Sneezing Runny nose Nasal congestion Frequent sinus infections

Throat: Heart burn Difficulty swallowing Feeling food getting stuck Painful swallowing

Respiratory: Cough Shortness of breath Wheezing Chest tightness Frequent pneumonias

Cardiovascular: Chest pain Palpitations History of fainting

Gastrointestinal: Nausea Vomiting Abdominal pain Diarrhea Blood in the stool Constipation Liver problems

Genitourinary: Kidney problems Kidney stones Frequent infections Incontinence

Musculoskeletal: Muscle pain Joint pain Joint swelling

Endocrine: Frequent urination Thirst Heat or cold intolerance

Neurological: Seizures Learning problems Migraines Numbness/tingling in extremities

Psychiatric: Stress Depression Anxiety Behavioral problems

Other Symptoms: Please List: _____

Review of Systems Completed: _____

Signature