



**CONTACT INFORMATION FORM
CONSENT TO RELEASE MEDICAL INFORMATION**

Best place we should leave messages:

- None
- On my voicemail at **Home** - Number _____
- On my voicemail at **Work** - Number _____
- On my voicemail for my **Cell** phone – Number _____

It is okay to discuss/leave message with:

- No one
- Any of the people listed below: (Name, Phone Number, Relationship)

Type of information to discuss or leave a message about:

- All information regarding my treatment - **OR**
- Laboratory results
- X-ray results
- Prescription Drug Information
- Medical Instructions or advice
- Other (specify): _____

Your Pharmacy Address & Phone

Number _____

Print Patient's Name

Signature of Patient (or Legal Guardian)

Date

New Patient History: Page 1 of 7

Name _____ Chart # _____
 DOB ___/___/___ SR _____

Welcome. Attended by Pt Fa Mo Spouse Sibling Friend _____
 Please complete the following information:
Briefly state what symptoms are bringing you here: _____

UPPER RESPIRATORY TRACT (NOSE, SINUS, EAR, AND EYE) PROBLEMS

Note: If no upper respiratory problems, check here and go to page 2 (Lower Respiratory Tract)

<input type="checkbox"/> sneezing <input type="checkbox"/> itching nose <input type="checkbox"/> nasal congestion/stuffiness <input type="checkbox"/> runny nose ● if so: <input type="checkbox"/> mucus clear <input type="checkbox"/> yellow/green <input type="checkbox"/> bloody <input type="checkbox"/> post-nasal drip <input type="checkbox"/> sore throat <input type="checkbox"/> decreased or absent sense of smell <input type="checkbox"/> nose bleeds <input type="checkbox"/> snoring <input type="checkbox"/> bad breath <input type="checkbox"/> nasal polyps ● if so: <input type="checkbox"/> surgery to remove <input type="checkbox"/> recurrent ear infections <input type="checkbox"/> ear plugging/popping/fullness <input type="checkbox"/> hearing loss ● if so: <input type="checkbox"/> hearing tested <input type="checkbox"/> hearing not tested <input type="checkbox"/> eyes itchy <input type="checkbox"/> eyes watery <input type="checkbox"/> eyelids swollen <input type="checkbox"/> history of broken nose <input type="checkbox"/> history of nasal septum deviated <input type="checkbox"/> history of hole in nasal septum	<input type="checkbox"/> previous nasal or sinus surgery ● if so, year(s): _____ <input type="checkbox"/> history of sinus infections ● if so: <input type="checkbox"/> 1 to 4 per year <input type="checkbox"/> more than 4 / yr <input type="checkbox"/> sinus X-Rays done ● if so, last one: _____ <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> sinus CT done ● if so, last one: _____ <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> ENT physician evaluation ● if so, year: _____ by Dr. _____ <input type="checkbox"/> previous allergy skin testing ● if so, last one: _____ <input type="checkbox"/> showed allergies <input type="checkbox"/> negative <input type="checkbox"/> previous allergy blood testing <input type="checkbox"/> previous allergy shots ● if so, for _____ years stopped: _____ (year) <input type="checkbox"/> still on shots <input type="checkbox"/> helpful <input type="checkbox"/> not helpful	Symptoms are aggravated by: <input type="checkbox"/> tobacco smoke <input type="checkbox"/> cold air <input type="checkbox"/> animals <input type="checkbox"/> workplace or school <input type="checkbox"/> dusting or vacuuming <input type="checkbox"/> odors or scents <input type="checkbox"/> yard work <input type="checkbox"/> weather change <input type="checkbox"/> being outdoors <input type="checkbox"/> aspirin / related meds <input type="checkbox"/> other: _____ Symptoms first began: <input type="checkbox"/> childhood @ age ____y <input type="checkbox"/> adult @ age ____y Symptoms are worse in <input type="checkbox"/> spring <input type="checkbox"/> summer <input type="checkbox"/> fall <input type="checkbox"/> winter Symptoms interfere with: <input type="checkbox"/> sleep <input type="checkbox"/> work / school <input type="checkbox"/> recreation
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Medications (prescription and over-the-counter) that have been tried **only for upper respiratory symptoms:**

	Past	Current	Helpful?		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no

New Patient History: Page 2 of 7

Name _____ Chart # _____

DOB ___/___/___ SR

LOWER RESPIRATORY (CHEST, LUNG) PROBLEMS

Note: If no lower respiratory problems, check here and go to page 3

- cough
 - if so: dry
 - mucus coughed up
 - clear
 - yellow/green
 - bloody
- shortness of breath
- nighttime awakening with symptoms
- wheezing
- asthma diagnosed
 - year first diagnosed: _____
 - frequent bronchitis as child
 - ER visits _____
 - ER visits _____
 - Last ER visit: _____
 - hospitalized _____ times
 - Last hospitalization: _____
 - ICU for asthma _____ times
 - On ventilator? ___yes ___no
 - _____ courses of steroids/year
- lips turn blue
- fingernails turn blue
- asthma not diagnosed **but**:
 - frequent bronchitis/"croup"
 - "respiratory troubles" as a child
 - inhalers like "albuterol" help
 - "steroid" medicine helps
- COPD diagnosed: _____ (year)

Previous pulmonary function testing:

- If so, date: _____

Previous chest x-ray:

- If so, date: _____

Symptoms occur in:

- spring
- summer
- fall
- winter

Symptoms are worse in

- spring
- summer
- fall
- winter

Frequency of coughing, wheezing, or shortness of breath:

- daily
- twice per week
- more than twice per week
- _____ times per month
- only seasonally (as above)

Symptoms are aggravated by:

- tobacco smoke
- cold air
- animals
- workplace / school
- dusting or vacuuming
- odors or scents
- yard work
- weather change
- being outdoors
- aspirin / related meds
- other: _____

Symptoms first began:

- childhood @ age _____y
- adult @ age _____y

Symptoms interfere with:

- sleep
- work / school
- recreation

Symptoms are:

- worsening
- unchanged
- improving

Medications (prescription and over-the-counter) that have been tried **only for lower respiratory symptoms:**

	Past	Current	Work well?		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no

Notes:

New Patient History: Page 3 of 7

Name _____ Chart # _____
 DOB ___/___/___ SR Dr _____

SKIN PROBLEMS

Note: If no skin problems, check here and turn over to page 4

<input type="checkbox"/> itching <input type="checkbox"/> excessively dry, scaly skin <input type="checkbox"/> recurrent skin infections <input type="checkbox"/> welts, hives <input type="checkbox"/> skin swelling <input type="checkbox"/> other symptoms: _____ _____ _____ Location of skin problems: _____ _____ _____	Symptoms first began: <input type="checkbox"/> childhood @ age ___y <input type="checkbox"/> adult @ age ___y _____ <input type="checkbox"/> Physician diagnosed rash as: _____ <input type="checkbox"/> Dermatologist diagnosed rash as: _____ Usual treatments for this rash: ___ Meds (see below) ___ Moisturizers ___ Baths ___ Other:	Symptoms are made worse by: _____ _____ _____ Symptoms interfere with: <input type="checkbox"/> sleep <input type="checkbox"/> work / school <input type="checkbox"/> recreation Skin is: <input type="checkbox"/> worsening <input type="checkbox"/> unchanged <input type="checkbox"/> improving
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Medications (prescription and over-the-counter) that have been tried **for skin problems:**

	<u>Past</u>	<u>Current</u>	<u>Work well?</u>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no

Notes:

Name _____ Chart _____

DOB ___/___/___ SR Dr _____

FOOD REACTIONS

Note: If no food reactions, check here and go to medication reaction below

Describe what reactions you have had after eating something, what you did, and what you do now (such as still eating some small amounts of this item, partial avoidance of the item, or strict avoidance with reading of labels):

Date: Food Item: Reaction: Notes:

Do you carry an Epi-Pen? ___yes ___no

If you have ever used it, describe:

MEDICATIONS or LATEX or STINGS REACTIONS

Note: If no allergic (or possibly allergic) reactions, check here and go to next page

Dates: Item causing reaction: Description of reaction: Notes:

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Name _____ Chart # _____

DOB ___/___/___ SR Dr _____

PAST MEDICAL HISTORY

Immunizations: Up to date Not up to date
Flu vaccine past year: No Yes, last taken in _____ (month) _____ (year)
Pneumonia vaccine: No Yes, last taken in _____ (month) _____ (year)
Chicken pox: No Yes, at age ____ years
TB test: No Yes, last done in _____ (month) _____ (year)

Heart problems? No Yes. Describe: _____
Past Heart Attack? No Yes. Treatment: _____
High blood pressure? No Yes. Treatment: _____(see meds below)
Headaches? No Yes. Treatment: _____
Diabetes? No Yes. Treatment: _____
Current smoker? No Yes, _____ packs per day.
Past smoker? No Yes, _____ packs per day for _____ years. Quit smoking: _____ (year)
Arthritis? No Yes. Treatment: _____

Alcohol use? No Two drinks per week More than 2 drinks per week
 Recreational drug use (such as cocaine, marijuana?) **[note: confidential]** No Yes

Hospitalizations:

Surgeries/Injuries: Tonsils and Adenoids Gall Bladder Knees Hips Sinuses Heart

Non-allergy medications (prescription and over-the-counter) that **you currently are taking:**

Medication	Dosage	Frequency	Medication	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Notes:

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Name _____ Chart # _____

DOB ___/___/___ SR Dr _____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children
Hay fever / allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<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"/>
Frequent bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cystic fibrosis in (any relatives): _____

Immune problems in (any relatives): _____

REVIEW OF SYSTEMS

GENERAL: recent weight loss night sweats Other: _____

HEAD: headaches head injury Other: _____

EYES: contact lenses cataracts Other: _____

MOUTH/THROAT: dryness of mouth hoarse voice trouble swallowing Other: _____

HEART: heart condition Describe: _____

GASTROINTESTINAL : heartburn/ulcers hiatal hernia liver disease
 frequent vomiting greasy stools Other: _____

GENITOURINARY: kidney trouble urine problems Describe: _____

MUSCULOSKELETAL: swollen hands/feet joint problems osteoporosis: _____

NEUROLOGIC: seizure disorder fainting spells Other: _____

BLOOD/LYMPHATIC: anemia bruise easily HIV positive Other: _____

ENDOCRINE: hypothyroid hyperthyroid diabetes Other: _____

Notes:

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Name _____ Chart # _____

DOB ___/___/___ SR Dr ___

ENVIRONMENTAL HISTORY

Lived in Colorado for ___ years. Previous states: _____

Fill in all that apply to your primary residence:

- city city-suburb rural-suburb farm
 house condo/townhouse apartment mobile home

Residence is _____ years old. I have lived there for _____ years.

Number of persons in household: _____

- basement finished basement unfinished earth floor in basement no basement
 no crawl space crawl space connects to inside crawl space connects to outside
 forced air heat hot water radiator heat electric heat gas space heater
 gas fireplace wood burning fireplace wood burning stove
 electrostatic filter fiberglass filters whole house HEPA filter room HEPA filter(s)
 central air window air conditioners swamp cooler attic fan
 portable fans ceiling fans
 central humidifier cold-mist humidifier ultrasonic humidifier steam humidifier
 current water leak: _____(location) previous water leak: _____(location)
 dust daily dust 1-3 times/week dust less than once per week seldom dust
 vacuum daily vacuum 1-3 times/week vacuum less than once per week seldom vacuum
 vacuum has bag vacuum has HEPA filter vacuum is water-filled

Patient's bedroom:

- main floor upstairs basement
 carpet hard floor
 curtains/drapes shades/blinds
 windows open in warm weather windows not open in warm weather
 waterbed spring/foam bed bunk bed futon
 feather (down) pillow non-feather pillow
 feather (down) comforter non-feather comforter

Pets: ___ dog(s) ___ cat(s) Other: _____ pets are in house pets are in bedroom

Smokers: ___ patient ___ spouse ___ father ___ mother Other: _____

Hobbies: _____

Away from home, patient is around: _____

Things in the environment that you feel may cause symptoms: _____

Patient's occupation:
 Father's occupation:
 Mother's occupation:
 Spouse's occupation:

Notes:

EXTRA NOTES

Name _____	Chart # _____
DOB ___/___/___	SR Dr _____