Date: __________

MISSISSIPPI Asthma & Allergy Clinic P.A.

INITIAL VISIT FORM

NAME: ____________________________ DATE OF BIRTH: ____________ REFERRING MD/PROVIDER: ______________

REASON FOR VISIT: ____

MEDICAL HISTORY: check if you have any of the following

	Asthma		Liver Disease		Blood disorder:
	Bronchitis		Eczema/Atopic Dermatitis		Cancer
	COPD/Emphysema		Psoriasis		Heart attack, date:
	Pneumonia		Diabetes		High blood pressure
	Tuberculosis		Thyroid Disease		Stroke
	Gastroesophageal Reflux		Glaucoma/Cataracts		Seizures
	Peptic Ulcer Disease		Diabetes	Other medical conditions:	
	Eosinophilic esophagitis		Anemia		

HOSPITALIZATIONS OR EMERGENCY DEPARTMENT VISITS WITHIN THE LAST TWO YEARS: check all that apply

	Asthma, date(s):		Blood infection, date(s):
	Pneumonia, date(s):		Allergic reaction, date(s):
	Other:		

SURGICAL PROCEDURES AND DATES: check here if none _____

SOCIAL HISTORY/HOME ENVIRONMENT: check all that apply

Home Type	___ House ___ Apartment/Condo ___Manufactured Home ___Long-Term Care Facility
Environment	___ Pets in home ___Carpeted Floors ___ Home tobacco/smoke exposure Other:
Occupation	___ Student ___Daycare ___Employed ___Retired
Substances	—— Current smoker: packs/day ___ years smoked ___ Former smoker: years smoked ___ date quit ___

ALLERGIES/ALLERGIC REACTIONS: Please indicate if you have had rash, shortness of breath, vomiting, diarrhea, lightheadedness, etc.
Please check here if no known allergies __________

Medications, Foods, Pollens, Insects, etc.	Symptoms

FAMILY HISTORY: (parents and siblings)

	Anaphylaxis, cause, if known:		Gastroesophageal reflux
	Asthma		Cancer
	Hay fever, nasal allergies		Diabetes
	Eczema/atopic dermatitis		Heart Disease
	Hives		Thyroid Disease
	Swelling/angioedema	Other:	

SEE BACK

Date: ___________

CURRENT MEDICATIONS: check here if you do not take any medications ________

	Yes	No		Yes	No
Do you have an epi-pen?			Previously on allergy shots? Date_________		
Previous skin or blood allergy testing? Date _______			Currently on allergy shots?		

CURRENT SYMPTOMS/PROBLEMS: check all that apply

	SKIN
	Hives/welts
	Itching
	Rash
	Other:
	EYES
	Dry eyes
	Itchy eyes
	Red eyes
	Watery eyes
	Other:
	EARS
	Hearing loss
	Itchy ears
	Recurrent ear infections
	Ringing in ears
	Other:
	NOSE
	Frequent nose bleeds
	Hoarseness
	Nasal congestion/stuffy nose
	Postnasal drip
	Recurrent sinus infections
	Runny nose
	Sneezing
	Snoring
	Other:

	THROAT
	Difficulty swallowing
	Frequent sore throat
	Frequent throat clearing
	Hoarseness
	Recurrent throat infections
	Other:
	RESPIRATORY
	Cough: ___dry ___productive
	Cough or wheezing with exercise
	Shortness of breath
	Wheezing
	Other:
	HEART
	Chest pain
	Leg swelling
	Palpitations
	Rapid heart rate
	Slow heart rate
	Other:
	NEUROLOGIC
	Fainting
	Headaches
	Excessive sleepiness
	Migraines
	Other:

	GASTROINTESTINAL
	Blood in stools
	Diarrhea (acute or chronic)
	Heartburn/GERD
	Recurrient vomiting
	Other:
	ENDOCRINE
	Excessive thirst
	Fatigue
	Weakness
	Weight gain
	Weight loss
	Other:
	ORTHOPEDIC
	Joint pain
	Joint swelling
	Other:
	KIDNEY
	Bedwetting
	Blood in urine
	Difficulty voiding/urinating
	Other:
	OTHER SYMPTOMS

IMMUNIZATIONS:

	Yes	No	Type, if known	Date(s)
Are immunizations up to date?				
Pneumonia vaccine(s)				
Flu vaccine				
COVID-19 vaccine(s)				
Reaction to any vaccination				

NAME OF PERSON COMPLETING FORM (please print)________________________________

SIGNATURE OF PERSON COMPLETING FORM: ________________________________

RELATIONSHIP TO PATIENT: circle one:

Self   Parent   Grandparent   Guardian   Other, please explain: ______________