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Cincinnati Allergy & Asthma Center
NEW PATIENT INTAKE FORM

Salutation: ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr.

Name: _____
First Middle Initial Last

I prefer to be addressed by my: ☐ First name
☐ Preferred nickname: _____
☐ Salutation and last name

If patient is a minor, please specify names of parent(s):

_____ _____

Do you have any relatives that are patients of the practice? ☐ No

☐ Yes, please name: _____

Please check the reason(s) for your visit (check all that apply):

- ☐ Environmental/seasonal allergies (congestion, runny nose, sneezing or eye symptoms)***
- ☐ Sinus issues (recurrent sinus infections, chronic sinusitis or nasal polyps)
- ☐ Asthma or breathing issues (wheezing, shortness of breath, chest tightness or cough)***
- ☐ Chronic cough (cough that has been present for 6 weeks or longer)
- ☐ Immunodeficiency (recurrent infections, CVID or IgG replacement therapy)
- ☐ Food allergy (history of hives/rash, swelling, breathing changes or anaphylaxis)
- ☐ Food allergy (history of abdominal pain, bloating/gas, diarrhea or constipation)
- ☐ Drug allergy (Penicillin, latex or other drug allergies)
- ☐ Eosinophilic esophagitis (difficulty swallowing or food impaction)
- ☐ Recurrent rashes (eczema, contact dermatitis or patch testing)
- ☐ Hives (raised/itchy bumps or welts)
- ☐ Angioedema (swelling of lips, eyes, tongue or other areas)
- ☐ Anaphylaxis/allergic reaction (confirmed or suspected allergic reaction)

Please complete additional questionnaire for environmental allergy and asthma consultations

In a few sentences, describe the specific reason(s) for your visit:

_____

_____

_____

Past Medical History

Please check all that apply to your personal health history

Respiratory
- ☐ Asthma
- ☐ Recurrent bronchitis
- ☐ COPD/emphysema
- ☐ Sleep apnea
- ☐ Recurrent pneumonia
- ☐ Vocal cord dysfunction

Cardiac
- ☐ Arrhythmia
- ☐ Coronary artery disease
- ☐ Heart failure
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Heart attack

Psychiatric
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression

Skin
- ☐ Atopic dermatitis (eczema)
- ☐ Contact dermatitis
- ☐ Psoriasis
- ☐ Urticaria (hives)

Gastrointestinal
- ☐ Celiac disease
- ☐ Crohn's disease
- ☐ Eosinophilic esophagitis
- ☐ Irritable bowel syndrome
- ☐ Lactose intolerance
- ☐ Ulcerative colitis

Endocrine
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Other
- ☐ Anemia
- ☐ Blood clots (DVT)
- ☐ Dementia
- ☐ Enlarged prostate
- ☐ Food allergy
- ☐ Glaucoma
- ☐ Kidney disease/renal failure
- ☐ Lupus (SLE)
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Cancer – specify type:

_____

- ☐ Other – specify:

_____

Allergies

Medication Name	Associated Reaction
1)	☐ Hives ☐ Rash ☐ Itching ☐ Shortness of breath ☐ Nausea/Vomiting ☐ Diarrhea ☐ Swelling ☐ Other:
2)	☐ Hives ☐ Rash ☐ Itching ☐ Shortness of breath ☐ Nausea/Vomiting ☐ Diarrhea ☐ Swelling ☐ Other:
3)	☐ Hives ☐ Rash ☐ Itching ☐ Shortness of breath ☐ Nausea/Vomiting ☐ Diarrhea ☐ Swelling ☐ Other:
4)	☐ Hives ☐ Rash ☐ Itching ☐ Shortness of breath ☐ Nausea/Vomiting ☐ Diarrhea ☐ Swelling ☐ Other:
5)	☐ Hives ☐ Rash ☐ Itching ☐ Shortness of breath ☐ Nausea/Vomiting ☐ Diarrhea ☐ Swelling ☐ Other:

If you have additional medication allergies to list, please inform staff

Current Medications

Medication Name	Dose	Directions (circle)
(EXAMPLE) Ibuprofen	*600 mg*	*Daily | 2x/day | 3x/day | As needed*
		Daily | 2x/day | 3x/day | As needed
		Daily | 2x/day | 3x/day | As needed
		Daily | 2x/day | 3x/day | As needed
		Daily | 2x/day | 3x/day | As needed
		Daily | 2x/day | 3x/day | As needed
		Daily | 2x/day | 3x/day | As needed

Past Surgical History

Please use space provided to specify approximate year of surgery or indicate if multiple surgeries

☐ Tonsillectomy (tonsils removed) _____

☐ Adenoidectomy (adenoids removed) _____

☐ PE tubes (ear tubes) _____

☐ Sinus surgery (FESS, polyp removal) _____

☐ Coronary artery bypass (open heart) _____

☐ Coronary artery stent _____

☐ Other: _____

Have you been hospitalized in the previous 5 years? ☐ No

☐ Yes – describe when/reason:

_____

_____

Family History

	Mother	Father	Brother	Sister	No History
Allergic rhinitis/hayfever	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Atopic dermatitis/eczema	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐
Recurrent infections	☐	☐	☐	☐	☐

Additional family history:

_____

_____

Social History

Living Situation:

☐ Apartment ☐ Condo ☐ House ☐ Other: _____

If patient is a minor, please complete the following section regarding home living situation:

☐ Child lives in a single household

☐ Child lives in multiple households – use space below to provide details regarding living arrangements that your doctor should be aware of (divorce, death of a parent, adopted, etc):

_____

_____

Pets/Animal Exposures: *check all that apply and specify number of animals*

☐ Cats _____ ☐ Dogs _____ ☐ Furry pets (rabbits, guinea pig, etc) _____

☐ Horses ☐ No pets in home but significant exposure through work/friend/relative

Tobacco use:

☐ Current (check all applicable): ☐ Cigarettes ☐ Electronic cig/vape ☐ Chew/dip

☐ Former (check all applicable): ☐ Cigarettes ☐ Electronic cig/vape ☐ Chew/dip

☐ Never

If current or previous tobacco use, specify type/amount:

- Cigarettes:
  - Number packs/day: _____ Number years smoked: _____
- If former smoker, year quit: _____

Drug use:

Do you use marijuana: ☐ No ☐ Yes, specify frequency: _____

Do you use any other drugs (cocaine, opiates, etc): ☐ No ☐ Yes, specify: _____

Employment:

☐ Unemployed/looking for work

☐ Homemaker/stay at home parent

☐ Employed – specify occupation/title: _____

☐ Retired – specify previous occupation: _____

Highest level of education achieved:

☐ Current grade level: _____ ☐ Some high school ☐ High school ☐ Some college

☐ Undergraduate degree ☐ Graduate degree ☐ Doctoral degree