Allergy and Asthma Specialist of Northeast Louisiana™

Joseph V. Giannobile, M.D., APMC

Adult New Patient Information

Name:_____ Date of Birth: _____

Primary Care Doctor:_____

Phone # (_____)_____

Would you like the office note from today's visit sent to your primary care doctor? ☐ Yes ☐ No

CHECK APPROPRIATE BOX AND FILL IN THE BOX AND FILL IN THE BLANK SPACES

YOUR HOME:

- Do you reside in a ☐ single home or ☐ apartment?
- How old is the residence? _____
- Do you have any pets? ☐ Yes ☐ No What kinds? _____
- Where do your pets live? ☐ Indoors ☐ Outdoors
- Is there anyone living in your home that smokes? ☐ Yes ☐ No
- Is your home air-conditioned? ☐ Yes ☐ No
- Is there a basement in your home? ☐ Yes ☐ No
- Do you have any hobbies that involve the use of glue or fabrics? ☐ Yes ☐ No

YOUR BEDROOM:

- Do you use feather or down pillows? ☐ Yes ☐ No
- Do you have carpet in your bedroom? ☐ Yes ☐ No
- Do you have upholstered furniture in your bedroom? ☐ Yes ☐ No
- Do you have curtains, drapes, or mini-blinds in your bedroom? ☐ Yes ☐ No
- Do you have any bookshelves in your bedroom? ☐ Yes ☐ No

***Name(s) of medications(s) to which you are allergic and descriptions of the reaction:**

_____

_____

_____

_____

FAMILY HISTORY: (check appropriate box)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Number and age of children:_____

- Is there anyone in your family diagnosed with:

Allergies	☐ Yes	☐ No	*relationship	_____
Asthma	☐ Yes	☐ No	*relationship	_____
Swelling	☐ Yes	☐ No	*relationship	_____

Other pertinent family History:_____

PAST MEDICAL HISTORY:

- Do you smoke? ☐ Yes ☐ No
- Did you ever smoke in the past? ☐ Yes ☐ No

Significant Illnesses:

_____

_____

_____

Hospitalizations, please list reason and approximate date:

_____

_____

_____

Surgeries, please list type and approximate date:

_____

_____

_____

REVIEW OF SYSTEMS

Check the box if you have recently experienced or received medical treatment for any of the following:

	YES	**NO**			
Constitutional			Chills	☐	☐
Fever	☐	☐	Night sweats	☐	☐
			Weight loss	☐	☐

	YES	NO
Weight gain	☐	☐
Fatique	☐	☐
Poor appetite	☐	☐
Inability to sleep	☐	☐
Eyes		
Ocular itching	☐	☐
Worsening eysight	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Eye irritation/inflammation	☐	☐
Ears/Nose/Throat		
Ear Pain	☐	☐
Ear Drainage	☐	☐
Hearing Loss	☐	☐
Ringing in ears	☐	☐
Nasal Blockage	☐	☐
Nasal Drainage	☐	☐
Sneezing	☐	☐
Bloody Nose	☐	☐
Sinusitis	☐	☐
Tooth Pain	☐	☐
Sore throat	☐	☐
Hoarseness	☐	☐
Cardiovascular		
Pain/tightness in chest	☐	☐
Heart murmurs	☐	☐
Swelling of feet	☐	☐
Rapid heart beat	☐	☐
Pain/aching in legs with exercise	☐	☐
High blood pressure	☐	☐
Respiratory		
Wheezing	☐	☐
Cough	☐	☐
Cough up phlegm	☐	☐
Cough up blood	☐	☐
Shortness of breath	☐	☐
Pneumonia	☐	☐
Painful to breath	☐	☐
Blood clot in lung	☐	☐
	YES	**NO**
Gastrointestinal		
Abnormal appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Black or bloody stools	☐	☐
Heartburn or indigestion	☐	☐
Difficulty swallowing	☐	☐
Stomach pain	☐	☐
Hemorrhoids	☐	☐
Jaundice or Hepatitis	☐	☐
Genitourinary		
Frequent urination	☐	☐
Discomfort on urination	☐	☐
Difficulty startin urination	☐	☐
Protein or blood in urine	☐	☐
Urinary or kidney infection	☐	☐
Kidney stones	☐	☐
Dribbling with coughing/sneezing	☐	☐
Female abnormal discharge	☐	☐
Male abnormal discharge	☐	☐
Musculoskeletal		
Joint Pain	☐	☐

Joint swelling	☐	☐
Arthritis	☐	☐
Muscle aches	☐	☐
Muscle weakness	☐	☐
Ulcers (open sores) on legs	☐	☐

	YES	NO
Integumentary		
Rashes	☐	☐
Lumps or pain in breasts	☐	☐
Discharge or bleeding from nipples	☐	☐
Edema (extra fluid on body)	☐	☐
Unusual hair loss	☐	☐
Neurological		
Headaches	☐	☐
Migraine headaches	☐	☐
Dizzy spells	☐	☐
Fainting/falling out	☐	☐
Seizures	☐	☐
Loss of memory	☐	☐
Numbess or burning in feet	☐	☐
Stroke	☐	☐
TIA (mini-stroke)	☐	☐
Difficulty with speech	☐	☐
Psychiatric		
Inability to sleep	☐	☐
Significant sleep disturbance	☐	☐
Significant mood disturbance	☐	☐
Depression	☐	☐
Endocrine		
Increased thirst	☐	☐
Increased urination	☐	☐
Goiter/Thyroid problems	☐	☐

Intolerance of heat	☐	☐
Intolerance of cold	☐	☐
Diabetis Mellitis	☐	☐
If so, are you taking insulin?	☐	☐
	YES	**NO**
Heme/Lymphatic		
Anemia or low blood count	☐	☐
Bruise or bleed easily	☐	☐
Swollen glands	☐	☐
Allergic/Immunologic		
Frequent hives	☐	☐
Frequent swelling	☐	☐
Recurrent sinus infection	☐	☐
Recurrent ear infections	☐	☐
Recurrent pneumonias	☐	☐

	Yes	No
Women only:		
Menstrual abnormalities	☐	☐
Men only:		
Prostate trouble	☐	☐
Weak urine stream	☐	☐
Pain or lump in testicles or scrotum	☐	☐
Discharge from penis	☐	☐

***Other recent medical problems?** ☐ Yes ☐ No

Please describe:_____

_____

_____

_____

Pharmacy:_____ Phone # (_____)_____

Please list current medications including strength and dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

(Do not write below this line)

I have reviewed the history with the patient and agree with the information provided in this form.

_____ _____

Signature of Physician Date