Kenwood
ALLERGY & ASTHMA CENTER, P.C.

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Macomb, MI 48044
Phone: (586) 846 – 3073
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FOR OFFICE USE:
PATIENT MEDICAL RECORD NUMBER: _____ STAFF INITIALS: _____

TODAY'S DATE: _____ APPOINTMENT DATE:_____

PATIENT'S FULL LEGAL NAME: _____ DATE OF BIRTH:_____

MALE: _____ FEMALE: _____ MARITAL STATUS: _____ ETHNICITY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

(Please circle which is preferred phone above number)

PERMISSION TO LEAVE A MESSAGE/TEXT MESSAGE? YES NO

EMAIL: _____ PATIENT'S OCCUPATION: _____

PATIENT'S EMPLOYER: _____ ADDRESS: _____

PRIMARY CARE PROVIDER : _____

ADDRESS: _____ PHONE NUMBER: _____

PHARMACY NAME: _____ PHONE NUMBER: _____

INSURANCE: _____ POLICY #: _____

INSURANCE PHONE #: _____ POLICY HOLDER: _____

POLICY HOLDER DATE OF BIRTH: _____

WHO CAN WE THANK FOR RECOMMENDING KENWOOD? _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT***: (NOTE: PATIENTS 18 YEARS OR OLDER ARE RESPONSIBLE FOR PAYMENT.)***

FULL LEGAL NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

RELATIONSHIP:_____ EMPLOYER: _____

STEP PARENT NAME(S): _____

***DIVORCED PARENTS: IT IS THE OFFICE POLICY THAT THE PARENT ACCOMPANYING THE CHILD WILL BE RESPONSIBLE FOR ALL BILLS*

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE NUMBER: _____

PATIENT NAME: _____PATIENT MRN: _____

REASON FOR TODAY'S VISIT/YOUR SYMPTOMS: _____

_____

Please circle any of the following that are problems for the patient:

Sneezing	Stuffy nose	Runny nose	Frequent sinus infections	Throat clearing
Hoarseness	Watery eyes	Red eyes	Itchy eyes	Hives
Eczema	Skin Itching	Lip swelling	Facial swelling	Wheezing
Cough	Shortness of breath	Chest tightness	Food reactions	Drug reactions

Food reactions (what food and what type of reaction): _____

_____

Drug reactions (which drugs and what type of reaction): _____

_____

Insect reactions (which insect and what type of reaction): _____

Previous allergy testing: Yes No If yes, when: _____

Previous allergy shots: Yes No If yes, when did you stop: _____

Previous allergist name and phone number: _____

If you have previously seen an allergist, it is requested that you bring a copy of your records to your initial appointment.

History of Illness:

When did the problems begin? _____

How often do the problems occur: (Circle all that apply)

Every day	Off and On	Rarely	with Exercise	Nighttime	Morning
Spring	Summer	Fall	Winter		

Other:_____

What makes the problems worse: (Circle all that apply)

Animals	Grass	Mold	Dust	Weeds	Foods	Exercise
Fumes/odors		Weather changes		Respiratory infections		

What makes it better? _____

_____

What medications have you tried to treat your symptoms? _____

_____

_____

PATIENT NAME: _____PATIENT MRN: _____

Please list ALL current medications:

Medication name	Dose	Frequency and time of day

Review of Systems & Medical History

Please circle all of the following symptoms you have had in the past or are currently experiencing.

General:	Chills	Fatigue	Fever	Night sweats	
	Weight gain	Weight loss	Sleep disturbance		
Head:	Dizziness	Headache	Recurrent sinus infections		Sinus Pressure
Ears:	Earaches	Clogged ears	Hearing Problems		Recurrent ear infections
	Ear drainage				
Eyes:	Drainage	Dry eyes	Itchy Eyes	Red eyes	Water eyes
	Dark circles	Cataracts			
Nose:	Itchy nose	Nasal congestion	Nose bleeds		Post nasal drip
	Runny nose	Sneezing	Nasal drainage		Sores in nose

PATIENT NAME: _____PATIENT MRN: _____

Throat:	Throat clearing	Hoarseness	Itchy throat	Sore throat	Throat infections
	Swallowing problems				
Heart:	Heart disease	High blood pressure	Racing heart	Heart palpitations	
Lungs:	Cough	Shortness of breath	Wheeze	Chest tightness	
	Difficulty exercising	Nighttime breathing problems			
GI:	Heartburn	Abdominal pain	Nausea	Vomiting	Constipation
	Bloating	Food intolerance	Diarrhea		
GU:	Frequent urination	Painful urination	Kidney stones	Prostate disease	
Endocrine:	Low blood sugar	High blood sugar	Hot/cold disturbance		Frequent steroid use
Musculoskeletal:					
	Back pain	Joint pain	Joint swelling	Neck pain	Osteoporosis
Skin:	Persistent itch	Hives	Eczema	Lip swelling	Facial swelling
	Bruising	Boils	Recurrent skin infections		

Neurologic:	Seizure disorder	Numbness	Tingling	Tremors	Migraine	Dizziness

PATIENT NAME: _____PATIENT MRN: _____

Psychological : Anxiety Depression Mental Illness

_____

_____

Hematologic: Bleeding disorders Blood clotting problem Cancer

_____

_____

Past Medical History

Past Hospitalizations:

Surgery	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History- Anyone in your family with the following:

Allergies: YES NO Relation: _____

Asthma: YES NO Relation: _____

High blood pressure: YES NO Relation: _____

Eczema: YES NO Relation: _____

Kidney disease YES NO Relation: _____

Food allergies: YES NO Relation: _____ Which food: _____

Thyroid disease YES NO Relation: _____

Hives: YES NO Relation: _____

Seizure disorder: YES NO Relation: _____

Strokes: YES NO Relation: _____

Other chronic conditions:

_____

_____

_____

_____

PATIENT NAME: _____PATIENT MRN: _____

Immunization History:

Childhood Immunizations Up to Date: YES NO

Last Flu Shot: _____ Last Pneumovax: _____

Social/Environmental History

Occupation: _____

Do your symptoms change at work? Worsen Improve

Recreational Activities that are impacted by Symptoms: _____

Tobacco Exposure: Please indicate your tobacco status by circling the following:

No Tobacco Exposure Current Smoker (How much and how many years) _____

Exposed to second hand smoke Past smoker (How long ago did you quit) _____

Pets:

Dog (How many) _____ Cats (How many) _____ Other pets_____

Do pets have access to bed or bedroom: Yes No

How old is your home? _____ How long have you lived there? _____

Type of home: House Condo Apartment Mobile home

Location: Suburb City Country Near water

Type of heating: Forced air Baseboard Hot water Wood Burning Steam Oil

Type of cooling: None Central air Window unit

Air purifier: None Central Room unit

Humidifier: None Room unit Attached to furnace

Dehumidifier: No Yes (Where is it located?) _____

Any recent water damages? Yes No

Bedroom: Carpet Tile Wood flooring

Feather bedding Feather pillows Allergy covers on pillows/mattress: Yes No

Age of mattress: _____ Age of Pillows: _____ Stuffed animals in bedroom? No Yes

Provider reviewed: _____ Date:_____