30170 23 Mile Road
Chesterfield Township, MI 48047
Phone: (586) 949 - 5900
Fax: (586) 949 – 5922

17965 Hall Road
Macomb, MI 48044
Phone: (586) 846 – 3073
Fax: (586) 846 - 3074

FOR OFFICE USE:

PATIENT MEDICAL RECORD NUMBER: _______________ STAFF INTIALS: _________________

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: ____

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 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 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 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 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:

____

____

____

____

Immunization History:

Childhood Immunizations Up to Date: YES NO

Last Flu Shot: _________________ Last Pneumovax: _______________ COVID Vaccinne: ________________

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:______________________________________