

Allergy & Asthma Associates

Specialized Care for Allergy,
Asthma and Sinus Disease

New Patient Questionnaire P. 1

Location: _____

Patient Name

Date of Birth

Today's date

Referring Physician

Accompanied Today By

Other Family Members Who Are AAA Patients

In the boxes below - please mark all that apply.

*Reason(s) for
Visit*

- | | |
|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> hay fever/nasal allergies | <input type="checkbox"/> ear problems |
| <input type="checkbox"/> rash/skin allergies | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> food allergy | <input type="checkbox"/> cough |
| <input type="checkbox"/> insect allergy | <input type="checkbox"/> shortness of breath/asthma |
| <input type="checkbox"/> eye problems | <input type="checkbox"/> chest infections |
| <input type="checkbox"/> headache/sinus problems | <input type="checkbox"/> Other: _____ |

First time problems
occurred? _____

(date)

When did this specific episode
start?

- 1 week ago 2 weeks ago
 3 weeks ago 4 weeks ago
 more than a month ago
 unknown

How often does this problem
occur?

- everyday once per week 2 x per week
 monthly several times a year unpredictable

Which month(s) is it most
severe?

- Jan Feb March April May June All year
 July Aug Sept Oct Nov Dec

What time of day are the
symptoms worse?

- morning noon afternoon nighttime all the time

Are symptoms worse in
certain locations?

- home work outside indoors other: _____

Suspected cause of problems?

- trees weeds grass mold dust perfumes scents latex
 weather changes heat cold cats dogs stress smoke
 other (animals, foods, etc.): _____

How would you grade the degree
of your symptoms in the last 4
weeks?

- none mild moderate severe

How would you grade your
degree of symptoms today?

- none mild moderate severe

How long have you lived in the area?

_____ days week(s) year(s)

Moved from where?

Where did you grow up?

Patient Name

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Review of Symptoms I

Please grade each of the following symptoms. **(Mark all that apply)**

	None	Mild	Moderate	Severe	
<i>Allergy/Sinus Symptoms</i>	Dark circles under eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy/watery eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Red eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Swollen/puffy eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear infections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear pain/pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear popping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congestion/blocked nose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased sense of smell:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nasal/sinus drainage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nose bleeds:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Runny nose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus infection:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus pressure/pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sneezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snoring:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snorting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post nasal/throat drainage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Throat clearing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	None	Mild	Moderate	Severe	
<i>Neurological Symptoms</i>	Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue/tired:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Headache:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lightheadedness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Problems sleeping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor concentration:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sleep apnea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Mild	Moderate	Severe	
<i>Asthma Symptoms</i>	Croup/laryngitis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest infections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest tightness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cough:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cough productive of mucus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congestion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath (SOB):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SOB with exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SOB at night:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name

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Review of Symptoms I - Continued

Please grade each of the following symptoms. **(Mark all that apply)**

	None	Mild	Moderate	Severe	
<i>Skin Symptoms</i>	Dry skin:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy skin:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rash:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Skin swelling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Mild	Moderate	Severe	
<i>Gastrointestinal Symptoms</i>	Constipation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diarrhea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heartburn/Indigestion/Reflux:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nausea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vomiting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Other:</i>	
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Review of Symptoms II

(Mark all that apply)

<i>General:</i>	<input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain
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<i>Ears:</i>	<input type="checkbox"/> drainage <input type="checkbox"/> hearing loss <input type="checkbox"/> rupture of eardrum
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<i>Eyes:</i>	<input type="checkbox"/> burning <input type="checkbox"/> dry
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<i>Mouth:</i>	<input type="checkbox"/> bad breath <input type="checkbox"/> gum problems <input type="checkbox"/> lip swelling <input type="checkbox"/> tongue swelling <input type="checkbox"/> pain in teeth <input type="checkbox"/> teeth grinding <input type="checkbox"/> mouth itching <input type="checkbox"/> mouth ulcers
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<i>Throat:</i>	<input type="checkbox"/> difficulty swallowing <input type="checkbox"/> swelling <input type="checkbox"/> loss of voice
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<i>Chest:</i>	<input type="checkbox"/> chest pain <input type="checkbox"/> heaviness/pressure <input type="checkbox"/> heart palpitations
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<i>Urinary:</i>	<input type="checkbox"/> excessive urination <input type="checkbox"/> excessive thirst <input type="checkbox"/> pain/burning with urination <input type="checkbox"/> difficulty with urination
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<i>Extremities:</i>	<input type="checkbox"/> swollen joints <input type="checkbox"/> painful joints <input type="checkbox"/> athletes foot/nail fungus
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<i>Neurological:</i>	<input type="checkbox"/> anxiety <input type="checkbox"/> stress <input type="checkbox"/> depression <input type="checkbox"/> numbness/tingling <input type="checkbox"/> tremors <input type="checkbox"/> developmental/growth delay <input type="checkbox"/> heat or cold intolerance
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<i>Other:</i>	
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Patient Name _____

Date of Birth _____

Today's date _____

Asthma History A.

Have you had breathing problems or asthma symptoms including coughing, wheezing, or shortness of breath over the past 2-4 weeks? Yes No

Number of Daytime Symptoms: _____ Frequency Daily Weekly Monthly

Number of Night Time Symptoms: _____ Frequency Daily Weekly Monthly

Have you been previously diagnosed with asthma? Yes No

If "No" previous diagnosis of Asthma, proceed to Section B

What was your age when your asthma began? _____ years months

During a typical week (in the past 12 months) how often did you use a Beta Agonist inhaler (like Proventil, Albuterol or Ventolin) for asthma?

less than once/week once or twice/week 3 x or more/week

daily more than once daily never

During a typical week, how often were your activities limited by asthma symptoms such as cough, wheezing, or shortness of breath?

less than once/week once/week 1 x or more/week daily never

During the past 12 months, how many times have you gone to the emergency room or had an urgent doctor's visit because of asthma?

none 1 x 2 x 3 x or more

Have you been admitted overnight to a hospital for asthma or breathing disorder in the last 12 months? Yes No

Do you get chest tightness, wheezing or shortness of breath within the first 15 minutes of exercise? Yes No

Do you check peak flows? Yes No

Best peak flow value _____

Do you have a written Asthma Action Plan? Yes No

Please complete entire section.

Asthma History B.

Did you ever have recurrent bronchitis, croup, asthma, reactive airway disease during childhood? Yes No

Have you had sudden severe episodes or coughing, wheezing or shortness of breath? Yes No

Have you had colds that go "to the chest" and take more than 10 days to get over? Yes No

Have you had coughing, wheezing, or shortness of breath in certain places when exposed to certain things (e.g. animals, tobacco, smoke, perfumes, etc.)? Yes No

Have you used medicine to help breathing? Yes No

If yes, do symptoms get better with medicine? Yes No

Do you get coughing, wheezing, or shortness of breath... Yes No

at night? Yes No

in the morning? Yes No

with exercise? Yes No

Other: _____

Sinus History

Do you have sinus problems? Yes No

If No - Go to Allergy History Section

How many times have you been treated for a sinus infection with an antibiotic in the past year?

none 1 x 2 x 3 x or more

Which antibiotic helped the most?

What is the color of your nasal drainage? **(Mark all that apply)**

clear brown white green yellow blood - tinged

Have you ever had nasal polyps? Yes No

Have you ever had an x-ray or CT scan of your sinuses? Yes No

Performed When? _____ Performed Where? _____

Patient Name _____

Date of Birth _____

Today's date _____

<i>Sinus History Continued</i>	Have you ever had sinus surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	When was the sinus surgery? _____	
	What type of surgery was it? <input type="checkbox"/> caldwel luc <input type="checkbox"/> ethmoidectomy <input type="checkbox"/> graft <input type="checkbox"/> rhinoplasty <input type="checkbox"/> septoplasty <input type="checkbox"/> turbinectomy <input type="checkbox"/> other: _____	
	Who was the surgeon? _____	
	Did the surgery help? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	
Do the sinus problems disturb your sleep enough to cause fatigue, tiredness or sleepiness during the day? <input type="checkbox"/> Yes <input type="checkbox"/> No		
General Other: _____		

<i>Allergy History</i>	Do you experience the following:		
	hay fever/nasal allergies		<input type="checkbox"/> Yes <input type="checkbox"/> No
	age when allergies/hay fever began? _____		<input type="checkbox"/> not sure
	food allergy/intolerance		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Please list details of food allergies below</i>		
	Foods: _____	Date of Onset: _____	Reaction: _____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	latex allergy		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Please list details of latex allergies below</i>		
	Product _____	Date of Onset: _____	Reaction: _____
	_____	_____	_____
	insect reaction		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Please list details of insect allergies below (Mark all that apply)</i>		
Insect:	Date of Onset:	Reaction:	
<input type="checkbox"/> fire ant	_____	_____	
<input type="checkbox"/> honey bee	_____	_____	
<input type="checkbox"/> mosquito	_____	_____	
<input type="checkbox"/> wasp	_____	_____	
<input type="checkbox"/> white faced hornet	_____	_____	
<input type="checkbox"/> yellow hornet	_____	_____	
<input type="checkbox"/> yellow jacket	_____	_____	
<input type="checkbox"/> not sure	_____	_____	
Have you ever been tested for allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How was testing performed? <input type="checkbox"/> skin <input type="checkbox"/> blood (rast)			
How long ago was the test? <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1 - 3 years <input type="checkbox"/> 4 + years			
<input type="checkbox"/> don't remember			
What were you allergic to? <input type="checkbox"/> trees <input type="checkbox"/> weeds <input type="checkbox"/> grasses <input type="checkbox"/> mold <input type="checkbox"/> dust mites			
(Mark all that apply) <input type="checkbox"/> cats <input type="checkbox"/> dogs <input type="checkbox"/> foods <input type="checkbox"/> insects <input type="checkbox"/> latex			
Did you get allergy shots? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How long did you take the shots? <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Weeks			
If yes, were the shots helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Who was your doctor? _____			
Where can we obtain your test results? _____			
Have you ever been prescribed an epipen (adrenalin/epinephrine)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, for what purpose? _____			
Other: _____			

Patient Name _____

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Today's date _____

General History

In the last 6 months, have you had a cough longer than 6 weeks in a row? Yes No

In the last 6 months, have you had hoarseness for greater than 6 weeks? Yes No

In the last 6 months, have you coughed up any blood or bloody sputum? Yes No

Have you had a chest x-ray in the last year? Yes No
 If yes, where was it performed? _____ When? _____
 What were the results? _____

Have you had the pneumonia vaccine shot (pneumovax)? Yes No
 If yes, when? _____

Do you normally get a flu shot every year? Yes No

Are your immunizations up to date? Yes No

During the last year, how many times have you had to take oral or injected steroids for allergies or asthma?
 none 1 x 2 x 3 x or more

During the last year, how many days have you missed school or work because of your allergies or asthma?
 none 1 day 2 days 3 x or more

During the last year, how many days have your allergies or asthma symptoms changed your productivity at work/school?
 none 1 day 2 days 3 x or more

How many times have you gone to the emergency room because of your allergies or asthma?
 none 1 x 2 x 3 x or more

How many times have you had to stay overnight at the hospital because of allergies or asthma?
 none 1 x 2 x 3 x or more

Are you pregnant? Yes No N/A

Date of last menstrual period? _____

Other Comments: _____

Social History

Occupation: n/a student hourly wage commission salary retired

Type of work: _____

Hobbies: _____

<u>Tobacco use/ exposure?</u>	<input type="checkbox"/> Current everyday smoker <input type="checkbox"/> Smoker, current status unknown <input type="checkbox"/> Former smoker <input type="checkbox"/> Current someday (social) smoker <input type="checkbox"/> Never smoked <input type="checkbox"/> Unknown if ever smoked
If Current or Former Smoker:	Type: <input type="checkbox"/> Chewing <input type="checkbox"/> Cigars <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Snuff Packs/Units per Day _____ Years Used _____ Ever tried to quit? Y N Year Quit _____

Passive/Second hand smoke exposure? Yes No Who/Where: _____

Do you drink alcohol? Yes No

Recreational drug use? Yes No

Do you have any HIV risk factors? Yes No Not sure

Environmental History**(Mark all that apply)**

Do you have any pets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Type of pets?	<input type="checkbox"/> cats	how many # _____						
	<input type="checkbox"/> dogs	how many # _____						
	<input type="checkbox"/> other	how many # _____						
Are they.....?	<input type="checkbox"/> inside	<input type="checkbox"/> outside	<input type="checkbox"/> both					
Do they sleep in the bedroom?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
How old is your home/apartment?	_____ years							
What type of flooring is in your home?	<input type="checkbox"/> carpet	<input type="checkbox"/> linoleum	<input type="checkbox"/> tile	<input type="checkbox"/> hardwood				
	<input type="checkbox"/> rugs	<input type="checkbox"/> other						
What window coverings are in your home?	<input type="checkbox"/> none			<input type="checkbox"/> cloth	<input type="checkbox"/> drapes	<input type="checkbox"/> wood shutters	<input type="checkbox"/> plastic/metal blinds	<input type="checkbox"/> other
Do you use any type of fans in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Do you use a fan in your bedroom?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
What type of heating/cooling system do you have?	<input type="checkbox"/> window units	<input type="checkbox"/> space heaters						
	<input type="checkbox"/> central air/heat	<input type="checkbox"/> other						
What exposure do you have at school/work?	<input type="checkbox"/> mold			<input type="checkbox"/> animals	<input type="checkbox"/> chemical exposure	<input type="checkbox"/> paint fumes	<input type="checkbox"/> smoke	<input type="checkbox"/> other
Has there been any water leakage or water damage in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Do you have visible mold or a musty odor in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
If patient is a child, does he/she attend daycare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A					

Family History

Race?	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Hispanic
	<input type="checkbox"/> More than one race	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown/Not Reported	
Ethnicity?	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Unknown/Not Reported		
Preferred Language?	_____				
Are there any family disputes/divorce situations that may make patient care more difficult?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

(Mark any family members who have experienced any of the listed conditions)

	Father	Mother	Brothers	Sisters	Children	Others
Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____					

Patient Name _____

Date of Birth _____

Today's date _____

Medical History

Please mark all that describe your current or past medical problems.

- | | | |
|----------------------------------------------|---------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> reflux | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> stroke | <input type="checkbox"/> diabetes | <input type="checkbox"/> chronic infections |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> emphysema | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> lupus/other | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> depression | <input type="checkbox"/> autoimmune disease | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> bipolar | <input type="checkbox"/> gout | <input type="checkbox"/> osteoporosis/osteopenia |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> arthritis | |
| | <input type="checkbox"/> fibromyalgia | |

Please list all previous hospitalizations/surgeries/prosthetics devices (artificial limbs).

Description

Year

_____	_____
_____	_____
_____	_____
_____	_____

Other:

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Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Street

City

State

Zip

Pharmacy Phone #: _____

Pharmacy Fax #: _____

Prescription Type:

90 day mail in

Local

Mail & Local

