NEW PATIENT INTAKE FORMS

Please answer ALL the following questions as completely and accurately as possible.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Birth Date</th>
<th>Appointment Date</th>
</tr>
</thead>
</table>

Occupation (please describe)

Days missed work or school/year

Hobbies

When and where did your allergy symptoms start?  Year  State  How long have you lived in New Jersey:

BRIEFLY DESCRIBE REASON FOR VISIT
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?
Circle or check items that apply and place an X under "No" if you have not suffered the symptom or if it does not apply.

<table>
<thead>
<tr>
<th>Present Problem</th>
<th>Past Problem</th>
<th>NO</th>
<th>CONDITION or SYMPTOM (circle words that apply)</th>
<th>Age at Onset</th>
<th>Factors that may increase these symptoms: animals, chemicals, dust, drugs, foods, infections, smoke, odors, weather, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hay Fever (itchy nose, sneezing, congestion, runny nose, stuffy nose, post nasal drip)</td>
<td></td>
<td>WORSENS: Spring? Summer? Fall? Winter?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Anaphylaxis</td>
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<td></td>
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<td></td>
<td>Eye Allergy Problems</td>
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<td></td>
<td></td>
<td></td>
<td>Headaches</td>
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<td></td>
<td></td>
<td></td>
<td>Migraines</td>
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<td></td>
<td></td>
<td></td>
<td>Frequent Ear Infections</td>
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<td></td>
<td></td>
<td></td>
<td>Chronic ear: crackling - popping - pressure</td>
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<td>Sinus Disease or Sinus Infections</td>
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<td></td>
<td></td>
<td></td>
<td>Asthma, wheezing, coughing, short of breath</td>
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<td></td>
<td></td>
<td></td>
<td>Bronchitis</td>
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<td>How many in the last 3 years?</td>
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<td></td>
<td></td>
<td>Pneumonia</td>
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<td></td>
<td>Dates</td>
<td></td>
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<td></td>
<td></td>
<td>Immune Defect-Frequent or Recurrent Infections</td>
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<td></td>
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<td></td>
<td>Insect Allergies (full details next page)</td>
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<td>Hives - Urticaria</td>
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<td>Allergy type swelling - Angioedema</td>
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<td>Eczema or other rashes</td>
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<td>Food Allergies</td>
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<td>Type of reaction?</td>
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<td>Reaction to latex, rubber, or elastic</td>
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<td>Reaction to make-up, skin care products, hair dye</td>
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<td></td>
<td>Reaction to jewelry or metals</td>
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</tbody>
</table>

Cornerstone Asthma & Allergy Associates, LLC
103 Old Marlton Pike Suite 211, Medford, New Jersey 08055
TEL (609) 953-7500 // FAX (609) 953-9085

 Reviewed & agree  

Nurse Initials  

EWB  JYK
**Current Medications:** List or attach all medications (Prescription and Over the Counter) taken routinely or on an as needed basis. Include any of the following: Aspirin, Advil, Tylenol, antacids, laxatives, vitamins & herbal products, sleeping pills, nose drops, eye-drops and all pills you take on a daily basis.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage &amp; Directions</th>
<th>Date Started</th>
<th>Doctor or Nurse Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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</tbody>
</table>

**Past Medications used for Allergy and Asthma** (include oral and topical corticosteroids, antihistamines, and nose sprays and inhalers)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage &amp; Directions</th>
<th>How well did it work?</th>
<th>Any Side Effects?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>None</td>
<td>Partial</td>
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<td>Great</td>
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<tr>
<td></td>
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<td>None</td>
<td>Partial</td>
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<td>Great</td>
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<td></td>
<td></td>
<td>None</td>
<td>Partial</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Great</td>
</tr>
</tbody>
</table>

**Drug Allergy or Intolerance**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction Year</th>
<th>Describe symptoms</th>
</tr>
</thead>
</table>

**Insect Allergy**  Bees, fire ant, hornet, yellow jacket, wasp, etc.

<table>
<thead>
<tr>
<th>Insect if known</th>
<th>Date</th>
<th>Describe symptoms</th>
<th>Describe treatment required</th>
</tr>
</thead>
</table>

**Hospitalizations or ER visits in the past 5 years?**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Date</th>
<th>Reason for treatment</th>
<th>Hospital (Name &amp; Address)</th>
</tr>
</thead>
</table>

NAME: _______________________________
DOB: _______________________________
Previous Allergist  |  ☐ No  ☐ Yes | Address | phone

Skin or Blood Tests?  |  ☐ No  ☐ Yes | List any positive results:

Did you receive allergy shots?  |  ☐ No  ☐ Yes | Treatment dates

ENT Doctor  |  ☐ No  ☐ Yes | Address | phone

Ear, nose or throat surgery?  |  ☐ No  ☐ Yes | List procedures & year:

Specialist  | (GI, Pulmonary, Dermatology?) | Address | phone

Procedures

Have you ever had any of the following?  |  When and Where? | Results?

Pulmonary Function  |  ☐ No  ☐ Yes
Sinus CT  |  ☐ No  ☐ Yes
Chest X-ray  |  ☐ No  ☐ Yes
TB test  |  ☐ No  ☐ Yes

Other:

Home Environment

Type of home  |  Approximate home age  | Any obvious mold growth or roof leaks?  |  ☐ NO  ☐ YES
Describe neighborhood (major plants, near horses, cows, wooded, lake):
Basement:  |  ☐ NO  ☐ YES  If so, damp/flooded?  |  ☐ NO  ☐ YES  // Finished?  |  ☐ NO  ☐ YES
Crawl Space:  |  ☐ NO  ☐ YES
Patient Bedroom:  |  Carpet  ☐  Hard Surface  ☐  Ceiling Fan  ☐  Plants  ☐  Stuffed Furniture  ☐  Stuffed toys on bed  ☐

Air conditioning?  |  Central  ☐  Room units  ☐  Routine Service?  |  ☐ NO  ☐ YES
Do you have an air cleaner?  |  ☐ NO  ☐ YES  Location:
What type of pillow do you have?  |  Feather  ☐  Synthetic  ☐  Other:
Comforter/Blanket?  |  Cotton  ☐  Down/Feather  ☐
Age of Mattress  |  Allergy proof encasing used?  |  ☐ NO  ☐ YES

Animal - Pet History

Are you around any animals  |  ☐ NO  ☐ YES  Have you noticed any symptoms around animals?  |  ☐ NO  ☐ YES
If so, describe:
Do pets sleep in your bedroom?  |  ☐ NO  ☐ YES  In your bed?  |  ☐ NO  ☐ YES

<table>
<thead>
<tr>
<th>Type</th>
<th>#</th>
<th>Age</th>
<th>Inside</th>
<th>Outside</th>
<th>In &amp; Outside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat</td>
<td></td>
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<tr>
<td>Dog</td>
<td></td>
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<tr>
<td>Rabbit</td>
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<tr>
<td>Bird</td>
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<tr>
<td>Hamster/Gerbil</td>
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<tr>
<td>Horse</td>
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</tbody>
</table>

NAME: __________________________________________
DOB: __________________________________________
**Personal History**

Smoking exposure: Work [ ] No [ ] Yes  Home [ ] No [ ] Yes  
Do you drink alcohol? [ ] No [ ] Yes  Average # / week  
Have you ever smoked [ ] No [ ] Yes  Year quit  
Do you presently smoke? [ ] No [ ] Yes  How long?  
What? Cigarettes  Cigars  Pipe  Average pack/day  
If you still smoke do you think you could stop? [ ] No [ ] Yes  

**Review of Systems:** Mark X under No if it does not apply to you, circle symptoms or diseases and describe when needed.

<table>
<thead>
<tr>
<th>NO</th>
<th>CONDITION</th>
<th>Notes (include any ailments not covered)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Constitutional:</strong> e.g. weight loss, fatigue, sleeping problems, fever, chills</td>
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<tr>
<td></td>
<td><strong>Eye Problems:</strong> e.g. glaucoma, acute vision changes, pain, light sensitivity</td>
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<tr>
<td></td>
<td><strong>Ear, Nose, Throat, Mouth:</strong> recurrent infections, hoarseness, difficulty smelling, ear pain, difficulty hearing, snoring, excessive mouth breathing</td>
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<td></td>
<td><strong>Cardiovascular:</strong> e.g. angina, chest pain, heart attack, high blood pressure arrhythmia, skipped beats, palpitations, flutter, murmur, rheumatic fever, mitral valve prolapse</td>
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<td></td>
<td><strong>Respiratory:</strong> e.g. embolism, tuberculosis, coughing blood</td>
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<td><strong>GI:</strong> e.g. trouble swallowing, heartburn, reflux, frequent use of antacids, nausea, vomiting, diarrhea, constipation, cramping, abdominal pain, irritable bowel syndrome, hiatal hernia, peptic ulcer, gallbladder, liver problems, hepatitis or liver inflammation</td>
<td></td>
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<tr>
<td></td>
<td><strong>Genitourinary:</strong> e.g. frequency, pain on urination, blood in urine, recurrent urinary tract infections, prostate problems, slow stream of urine in men, kidney problems, cancer, hysterectomy, ovaries removed</td>
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<td><strong>Musculoskeletal:</strong> e.g. Arthritis, broken bones, osteoporosis, autoimmune disorders</td>
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<td><strong>Skin Problems:</strong> e.g. Rashes, acne, psoriasis, sunlight sensitivity</td>
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<td><strong>Neurological:</strong> e.g. headache, numbness, tingling, pain, stroke, TIA,</td>
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<td><strong>Endocrine:</strong> e.g. diabetes, thyroid disease</td>
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<td></td>
<td><strong>Cancer:</strong> any type and treatment received</td>
<td></td>
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<tr>
<td></td>
<td><strong>Psychiatric:</strong> e.g. depression, eating disorders, anxiety, thoughts of suicide</td>
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<tr>
<td></td>
<td><strong>Hematologic Lymphatic:</strong> e.g. anemia, enlarged lymph nodes</td>
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<tr>
<td></td>
<td><strong>Other Ailments:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Family Allergy History**

<table>
<thead>
<tr>
<th>Is there a family history of allergies?</th>
<th>Father</th>
<th>Mother</th>
<th>Fathers</th>
<th>Mothers</th>
<th>Siblings</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td></td>
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</tr>
</tbody>
</table>

Nose or Eye Allergies  
Asthma  
Hives  
Eczema  
Food or Bee Allergies  
Immune Deficiency Disorder  
Drug Allergies  
Autoimmune Disease

Thank you for taking the time and effort to fill this form as completely and accurately as possible. Your information will allow us to give you the best appropriate care possible.

Patient Name: ____________________________  
Patient Signature: _________________________  
Guardian Signature: _______________________

Nurse Signature: _________________________  
Physician / Date: _________________________  
EWB  JYK