NEW PATIENT FORM

(Please complete *prior* to your visit)

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Phone: 508-759-7555, Fax: 508-759-7355
40 Tremont Street, Duxbury, MA 02332,
Phone: 781-934-6200, Fax: 781-934-9118

NAME: ________________________________ **DATE OF BIRTH:**____/____/____ **AGE:**______

APPOINTMENT DATE:_____/_____/_____ **TIME:**___________

****REASON FOR VISIT:**____

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Do you have any of the following?

	Please circle	**Details**
Asthma	Yes / No	Date of Diagnosis:
Environmental allergy	Yes / No	Pollen Mold Dust Animals Other:
Food allergy	Yes / No	Foods:
Venom (insect sting) allergy	Yes / No	Date of Reaction:
Medication allergy	Yes / No	List medication and reaction: ____________________ ____________________ ____________________ ____________________
Hives	Yes / No	Date of onset:
Eczema	Yes / No	Body parts involved:
Nasal polyps	Yes / No	
Sinus infections	Yes / No	How many per year?
Prior sinus surgery	Yes / No	What type/when?
Pneumonia	Yes / No	How many per year?
Latex allergy	Yes / No	
Contact dermatitis	Yes / No	Causes identified:

*****PLEASE COMPLETE BOTH SIDES**

PATIENT NAME: ______________________________ DATE OF BIRTH: ____ / ____ / _____

MEDICAL HISTORY - Do you have any of the following? Please circle:

High blood pressure High cholesterol Diabetes Osteoarthritis Heartburn/Reflux

Kidney problems Autoimmune problems Heart Problems Thyroid problems Cancer (type/treatment?)

Other:

SURGICAL HISTORY - Please list all surgeries and dates:

SOCIAL HISTORY: (Please circle)

Type of dwelling? House / Apartment / Condo / Townhome
How long have you lived there? How old is the building?
Flooring in home: wall-to-wall carpet / hardwood / area rug
Do you have a basement? Yes / No If yes, is it: Wet / Dry Any visible mold in basement? Yes / No
Do you use a dehumidifier? Any visible mold elsewhere in home? Yes/No

Your Bedroom: Type of pillows: Type of mattress: Allergy covers?: Yes / No
Bedroom Flooring: wall-to-wall carpet / hardwood / area rugs
Heating: Forced hot air / Forced hot water / Electric / Wood stove / Fireplace

Pets in home: None__________ Dogs________ Cats_________ Other _________
Occupation:

Have you ever smoked? Yes / No How many years?_____ How many per day/week?________
Are you currently smoking? Yes / No If not, date stopped? ___________________________
Exposure to second-hand smoke in current home? Yes / No
Do you drink alcohol? Yes / No If so, how much and how often?

MEDICATIONS - List all current medications (prescriptions, over-the-counter, supplements):

Name and Strength	How Often?	Name and Strength	How Often?

FAMILY HISTORY - Does anyone in your family have the following? Please check:

	Father	Paternal Siblings	Paternal Grandparents	Mother	Maternal Siblings	Maternal Grandparents	Brother	Sister
Asthma								
Environmental allergies								
Food allergies								
Medication allergies								
Sinusitis								
COPD/Emphysema								

******PLEASE COMPLETE BOTH SIDES**