

333 International Drive, Williamsville, NY 14221

(716) 633-5277

6941 Elaine Drive, Suite 2, Niagara Falls, NY, 14304

Patient Intake Form

First Name: _____ **Last Name:** _____ **DOB:** _____ Male Female

Home: Apartment House Mobile Home Age of Home _____ years

Living area: Carpet Wood **Bedroom:** Carpet Wood

Bedding: Age of Bed _____ years Allergy covers: Mattress Pillow None

Heating System: Forced hot air Hot water Steam Wood Burning stove Radiant

Air Conditioning: Central Window units None

Pets: _____ Inside In bedroom Outside

Pets exposure at: Friends/Family _____

Smoking: Current Smoker _____ PPD for _____ yrs Never Smoked

QUIT smoking _____ yr ago Smoked from age _____ to age _____ Max smoked _____ PPD

Exposed to passive smoke: Mom Dad Present at friends home Work **Other** _____

Patients Occupation: _____

Parent's Occupation: Mom: _____ Dad: _____

Patients' Hobbies: _____

Pharmacy Information - Name: _____ **Phone #:** _____

Patients Surgical History: (Please List Surgery and year/age)

Please List All Current Medical Problems: _____

Allergies: (Please list all drug and food allergies both prescription and over the counter)

Drug and Reaction

Food and Reaction

Please list all current medications and supplements:(Bring with you)

Previous Allergy Testing?

Physician _____ When _____

Allergy Shots No / Yes How long _____ years **Last PPD (Test for Tuberculosis)** _____

Date of last Chest X-Ray _____ **Date of last Sinus X-Ray/CAT Scan** _____ **Date of Pneumonia Vac** _____

Previous Pulmonary Evaluation Yes No Who _____

Previous ENT (Otolaryngologist) Evaluation: Yes No Who _____

Family History of Allergies, Asthma, Atopic Dermatitis: N / Y

Mothers Side of Family

Fathers Side of Family

Asthma N / Y _____
 Allergic Rhinitis N / Y _____
 Lupus N / Y _____
 Rheumatoid Arthritis N / Y _____
 Scleroderma N / Y _____

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Please Sign _____ **Date** ____/____/____