Today's Date: _____

Live Oak

ALLERGY • ASTHMA • IMMUNOLOGY

New Patient Questionnaire

Patient's Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

How did you hear about us? ☐ Internet ☐ Physician ☐ Family/Friend _____

☐ Magazine _____ ☐ Direct Mailer

May we leave a confidential message on your voicemail? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Sex: ☐ Male ☐ Female

Race: ☐ African American ☐ American Indian or Alaska Native ☐ Asian ☐ Caucasian

☐ Native Hawaiian or other Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Telephone: _____

Primary Medical Insurance

Company: _____ Effective Date: _____

Insurance Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's ID #: _____ Group or Account #: _____

I authorize release of any medical information necessary to process this claim and request payment of insurance benefits be paid directly to Live Oak Allergy, Asthma & Immunology. I also authorize releases of medical information necessary to process disability, loss of income, or any other form requested by myself or my insurance company on my behalf. I further authorize the release of above information via FAX transmission.

Patient Signature: _____

Witness Signature:_____

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Primary Reason for evaluation: _____

_____

_____

Allergy History: (List all medications/other substances that you are allergic to or have caused an adverse reaction.)

Medication / Substance	Reaction

Check all that you are allergic to, when the allergy occurs (spring, summer, fall, winter) and what kind of reaction you have.

- ☐ Dust: _____
- ☐ Pollen: _____
- ☐ Mold/Mildew: _____
- ☐ Animals: _____
- ☐ Foods: _____
- ☐ Other: _____

Have you ever had allergy testing?	☐ No	☐ Yes	If yes, when?_____
Have you ever had allergy shots?	☐ No	☐ Yes	If yes, when?_____
Have you ever had a chest x-ray?	☐ No	☐ Yes	If yes, when?_____
Have you ever had a breathing test?	☐ No	☐ Yes	If yes, when?_____
Have you ever had sinus surgery?	☐ No	☐ Yes	If yes, when?_____

Past Medical History: (List your current/past health problems.)

_____

_____

_____

Past Surgical History:

1. _____
2. _____
3. _____

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Current Medications: (Please list all medications you are currently taking including herbs, vitamins and over the counter medications.)

Medication	Dose	How Often

Pharmacy Name: _____ Phone Number: _____

Family History:

	Age	Alive/Deceased	Health Problems	Cause of death
Mother				
Father				
Sibling				
Sibling				
Other_____				

Social History:

Are you married? ☐ No ☐ Yes How many years?_____

Number of children: _____

Where do you work / what do you do? _____

Any unusual work / home exposures? If so what? _____

Where are you from? _____ How long have you lived in Georgia? _____

Alcohol History:

Do you consume alcohol? ☐ No ☐ Yes If yes, ☐ Daily ☐ Social

Tobacco History:

Smoking status: ☐ Every day smoker ☐ Never smoked ☐ Former smoker

☐ Cigarettes Packs/Day: _____ Years:_____ Date Quit: _____

☐ E-cigarettes ☐ Cigars

Illicit Drug History:

Do you use illicit drugs? ☐ No ☐ Yes

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Environmental History:

Residence Location: ☐ Urban ☐ Rural ☐ Suburban

Type of Residence: ☐ Apartment ☐ House ☐ Mobile Home

Smokers in residence: ☐ Yes ☐ No

Air conditioner: ☐ Central ☐ Window unit ☐ None

Heating system: ☐ Forced air ☐ Radiator ☐ Space heaters ☐ Fireplace ☐ None

How often are filters changed? _____

Type of floors:

Living area: ☐ Carpet ☐ Wood ☐ Vinyl/Tile

Bedroom: ☐ Carpet ☐ Wood ☐ Vinyl/Tile

Type of bed: ☐ Traditional Mattress ☐ Foam/Tempurpedic ☐ Waterbed

Dust mite encasements in place: ☐ No ☐ Yes

Type of pillow: ☐ Feather ☐ Synthetic (cotton/polyester) ☐ Foam

Dust mite encasements in place: ☐ No ☐ Yes

Pets: ☐ No ☐ Yes

Pet	Outdoor	Indoor	Spends time in bedroom

Do you keep house plants? ☐ No ☐ Yes

Vaccinations:

Do you receive a flu shot every year? ☐ No ☐ Yes

When was your last flu shot? _____

Have you ever had a pneumonia vaccine? ☐ No ☐ Yes Date: _____