INFORMATION FORM

Patient______________________________ Male / Female Birth Date__________ Age _____

Address______________________ City__________________ State _____ Zip______

Home Phone ___________________ Work Phone __________________ Ext____ Cell Phone __________________

Marital Status (S M D W O) Student ____ F P Spouse __________________ Spouse's DOB __________

Social Security ___________________________ Driver's License ___________________________

Employer ___________________________ Full / Part Time Years Employed _________________

Address ______________________________ Town __________________ State ______ Zip _________

Primary Care Physician _________________________________

PERSON RESPONSIBLE FOR ACCOUNT (If patient is a minor please complete next section)

Mother's Name ___________________________ Date of Birth ___________________ Age________________
Address __________________________________ City ___________________________ State ______ Zip _________
Employer _________________________ Status ___________ Years of Employment ___________________
Social Security Number __________________________
Father's Name ___________________________ Date of Birth ___________________ Age________________
Address __________________________________ City ___________________________ State ______ Zip _________
Employer _________________________ Status ___________ Years of Employment ___________________
Social Security Number __________________________

INSURANCE INFORMATION

Primary Carrier ______________________________ Policy # __________________ Group #_______________________
Sponsor/Employer __________________________ Referral Y / N Effective Date __________________ Copay $_____

Secondary Carrier ___________________________ Policy # __________________ Group #_______________________
Sponsor/Employer __________________________ Referral Y / N Effective Date __________________ Copay $_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name_______________________ Relationship _____________ Phone (Home)______________- (Cell)_____________

WHO SHOULD WE THANK FOR THIS REFERRAL?

NAME _________________________

Financially Responsible

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default. Payments including: co-payments are expected at the time of service, for new evaluation, Office visits, and Allergy injections. Accounts with balances over 30 days will be subject to 1% monthly (12% APR) late payment charges. It is the patient's responsibility to obtain a valid referral if required by your HMO carrier. Services rendered without such valid referral will be the patient's responsibility.
I have read and fully understand the policies and procedures of this office.

Signature ____ Date_____________________________

Patient's Name ____ Age _____ Date of Birth ___________________ Male/Female Today's Date __________________

Do you wear Latex Gloves Daily? ________ Do you use Latex Products Daily? ________ How many Surgeries have you had? Total _________
Do you have Eczema or other Rashes on your hands? __ If yes, explain ____
Have you had itching, swelling, or other symptoms following dental, rectal or pelvic exams? _______________
Have you experienced swelling or difficulty breathing after blowing up a balloon? ______________
Do condoms, diaphragms, or Latex sexual aids cause itching or swelling? _____________
Do rubber handles, rubber bands, or elastic bands on clothing cause any discomfort? _____________

Do any of the Foods listed below cause Hives, itching of the lips or throat, or any more severe symptoms after handling/ingestions?

Apple	Apricot	Avocado	Banana	Carrot	Celery	Passion Fruit
Grape	Hazelnut	Kiwi	Melon	Nectarine	Papaya	Fig
Pear	Pineapple	Plum	Potatoes	Tomatoes	Chestnut	Peach

Marital Status _______________ Education Status ____________________ Occupation ________________________ Employer __________________________
Occupational Exposure ____ Recent Travel ____
Hobbies (Indoor/Outdoor) ____

Do you Smoke? _____________ (Cigarettes, Cigar, Pipe, Other) __________________ # per day How long ________ Years
Have you considered quitting? _____ When did you quit? ________________ Are you exposed to others smoking? ________ Estimated Quit Date _______________

Do you drink Alcoholic Beverages? ________ If yes, how many per week? _____ What type ______________ Do you get Congested? _______________
Do you use illegal drugs? _______________ If yes, please explain ____

FAMILY HISTORY

Living/Deceased Age Medical Conditions/Cause of Death	*Living/Deceased Age Medical Conditions/Cause of Death*
Mother ______________________	Father ______________________
Mat Grandmother ______________________	Pat Grandmother ______________________
Mat Grandfather ______________________	Pat Grandfather ______________________
Aunt/Uncle ______________________	Aunt/Uncle ______________________
Sibling/Child ______________________	

ENVIROMENTAL HX

Location of where you live? City Suburb Country/Farm Seashore Other
Do you live in a (style): Home Condo Apartment Dorm Other
Number of Floors ____________ Age of Residence ___________ Length of Occupancy ________ months/years

Heat: Oil Gas Electric Baseboard Radiators Forced Air Other
Air Conditioning: Central Window Other None
Humidifier: Central Separate Units Other None **Air Filtration:** Yes No Frequency Changed: ______________
Basement: Damp Musty Seepage/Flooding None

Do you have pets? ___________ If yes, described ____ How Many ________________ How long exposed ___________
Are Pets allowed in your bedroom? ________________ What kind of Pets have you had previously? ____

Please indicate contents of furnishings in your environment (stuffed, feathers, foam, wool, tile, linoleum, cotton, and synthetic, other, unknown)
Flooring/Padding: Living Room __________________ Bedroom __________________ Basement ___________________________
Bedroom: Sleeps Alone Shares Other
How often do you change your bed linens? __________ What Water Temperature are your linens washed? _____________________
Box Spring/Mattress _________ Waterbed _______ Other __________
Pillows ____________ Comforter _______ Linens __________
Allergy control Encasements on: Box Spring ___ Mattress ___ Pillows ___ Comforter ___
Window Treatments: Curtains _________ Blinds ___________ Shades ___________ Other ____________ None ____________
Have you had any new Environmental changes, books, trophies, stuffed animals, games, collections at: Home _________ School ________ Work ________

LPN/RN ____ MD____

Patient's Name ______________________________________ Age _____ Date of Birth _________________ Male/Female Today's Date ________________

Primary Care Physician _____________________ Referred By: ____________________ Pharmacy Name: ________________Mail Order/Local

In your own words please describe your symptoms/problems you wish to be discussed today. ***Please include when it began, how often, when is it worse day/night, how long it lasts. What makes it better, what makes it worse?*** Do your symptoms interfere with your activities, are you ever symptom free?

____

____

____

____

____

Circle months affected: January February March April May June July August September October November December ALL YEAR

How many colds do you have each year? 1-2 3-5 6-12 more than 12

Have you ever been evaluated by an Allergist? _______ If yes, Name ____ and when ________________

Have you ever had Allergy Skin Testing? _______ If yes, when __________________ Have you ever received Allergy Injections? ________ How long ________

Have you ever had Cortisone injections? _______ If yes, when and for what ____

Has there been difficulty sleeping at night due to the symptoms of Allergy? ____

Please List **ALL Medications** (**PRESCRIBED and OVER THE COUNTER**) that you are taking at the present time and the reason for taking them

Medication	Dosage	How many times per day	Last Dose	Reason for taking

Do you have Allergies to Medications or Foods?

____

____

Do any of the following cause or make your symptoms worse. Please circle what you have noticed to bother you or make your symptoms worse.

Foods	Indoor heat in winter	Hair spray	Insect Spray	Dust	Guinea Pig/Gerbil
Perfume	Cigarette Smoke	Feathers/Pillows	Zoo	Powder	Raking Leaves
Cats	Odors	Change of Seasons	Newspapers	Tooth Pain	Rubber
Birds	Change in Weather	Paint Lacquer	Excitement/Emotions	Mice	Horses
Paint Fumes	Exertion (running)	Farms	Rabbit	Wax	Cold Air
Mold/Mildew	Dog	Glue	Dampness	Circus	Cleanser
Grass	House Plants	Soap	Weeds	Hamsters	Barn Hay

Last Eye Exam ______________ Last Physical Exam ___________________ Last Dental Exam ____________________

(Doctor) ____________________________ (Doctor) ___________________________ (Dentist) ____________________________

Last PAP Smear _____________ Last Mammogram __________ First Date Last Menses _______________ Length/flow ________________ Menopause _____

LPN/RN _______________________________________ MD____

Patient's Name ____ Age _____ Date of Birth __________________ Male/Female Today's Date _________________

Please circle any below that you have or have had in the past.

Hay Fever
Runny Nose
Itching of the ears
Sinus Headaches
Sinus Infections
Ear Infection (R/L)
Itching of the roof of mouth
Sinus Problems
Ear Fullness/Popping
Ear Drainage (R/L)
Post Nasal Drip
Sneezing
Red Itchy/Watery Eyes
Ringing in the Ears (R/L)
Nose Bleeds
Tonsillitis
Smelling Impairment
Loss of Hearing (R/L)
Nasal Discharge
Lightheadedness/Vertigo
Stroke (CVA)
Difficulty Swallowing
Dizziness/pass out
Changes in Appetite/Weight
Migraine Headaches
Epilepsy/Seizures
Polio
Fatigue/Weakness
Diabetes

Asthma
Wheezing
Coughing
Shortness of Breath
Hospitalization/Asthma
Emergency Visits/Asthma
Bronchitis
Tingling Hands/Feet
Freq Awakening 2am-6am
Croup
Pneumonia
Voice Changes
Pleurisy
Tuberculosis
Hives
Swelling of the Face
Swelling of the Lips
Persistent Coughing
Life Threatening Reaction
Food Allergy
Throat Tightness
Intubation
Hoarseness
Cold Extremities
Bulimia/Anorexia
Hair Loss
Chemical Dependency
Depression
Scleroderma

Dryness of Skin
Eczema/Dermatitis
Swelling from Insect Bites
Reaction Soap/Detergent
Reaction Nickel/Metals
Penicillin Allergy
Sulfa Allergy
Other Drug Allergy
Reaction Poison Oak/Ivy
Reaction to Latex
Glaucoma (R/L)
Double Vision
Cataracts (R/L)
Color Blindness
Breast Lumps (R/L)
Abnormal PAP Smear
Cancer (Type)
Thyroid under/over active
Lupus
Easy Bruising
Ulcer
Arthritis
Joint Pain
Twitching
Sleep Disturbances
Loss of Consciousness
Psychiatric Care
Anxiety
Palpitations

Heart Disease
Hypertension
Heart Murmur
Rheumatic Fever
Scarlet Fever
Irregular Heart Rate
Pacemaker
Kidney Stones/Disease
Testicular Masses/Cancer
BPH (Benign Prostate Hypertrophy)
Bowel Habit Changes
Hemorrhoids
Jaundice
Diarrhea
Hepatitis
HIV positive/AIDS
Mouth Sores
Liver Disease
Alcoholism
Bleeding Disorder
Fevers
Urinary Incontinence
Unexplained Fevers
Phlebitis
Skin Color Changes
Intolerance to Cold
Loss of Strength
Fractures/Trauma

Past Surgeries: ____

LPN/RN ______________________________ MD______________________________________

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PHOTOGRAPH CONSENT

I, ____________________________________, give Dr. McGrath and his staff permission to use my picture for the purpose of patient identification.

Signed: _____________________________

Date: _______________________________