ALLERGY THERAPEUTICS

PATIENT INFORMATION

Last Name_____ First Name _____ Date _____ Address

Zip Code _____

Telephone Home _____ Work _____ Cellular _____ Email

Address:_____ Age____

DOB _____ Occupation _____ Who to

reach in case of an emergency _____ Contact # _____ How did

you hear about our clinic? _____ Are you

currently receiving health care? Please circle: Y N

If yes, name of physician:_____ Condition

being treated: _____ What are

your most important health concerns?

1 _____

2 _____

3 _____

Please list tested or suspected allergies and related symptoms:

Foods _____ Seasonal

_____ Drug /

other _____ Current

Medications: Please list any prescription medications or over-the-counter medications you are taking.

_____

Daily Dosage _____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? Do you _____

smoke? Please circle: Y N

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the items listed on the New Patient Information form.

Signature _____ **Date** _____

(If under the age of 16, must be signed by Parent or Legal Guardian.)