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