PATIENT INFORMATION

Patient Full Name _____ Birthdate _____
First MI Last

Address _____ Home Phone (___)_____

City _____ State _____ Zip _____ Cell Phone (___)_____

Sex Male Female Marital Status: Divorced Married Single Widowed

Place of Employment _____ Phone _____

Race: Black Caucasian Other_____ Language: English Spanish Other_____

Ethnicity: Hispanic Non-Hispanic

SPOUSE'S NAME _____ Spouse's Birthdate _____

Spouse's Cell Phone _____ Place of Employment _____

Who May We Contact in Case Of Emergency? _____

Phone _____ Relationship _____

PRIMARY CARE PHYSICIAN _____ Phone _____

List Other Doctors You See _____

IF THE PATIENT IS A MINOR:

Father's Name _____ Home Phone _____

Father's Address _____ Cell Phone _____

Date of Birth _____ Father's Place of Employment _____

Mother's Name _____ Home Phone _____

Mother's Address _____ Cell Phone _____

Date of Birth _____Mother's Place of Employment _____

Person Responsible for Account _____

Primary Insurance Carrier _____

ID # _____ Group # _____

Insured's Name _____ Birthdate _____

Secondary Insurance _____ ID #_____

Insured's Name _____ Birthdate _____

Patient Name_____ **Date** _____

In your own words, briefly describe the problem that brings you here:

How long have you had this problem? _____

Symptoms occur (circle all that apply):
Seasonal spring summer fall winter every day all year intermittent

I am here for the following medical problems (circle all that apply):
cough wheeze headache nasal stuffiness nasal drainage sinus infections
asthma bronchitis chest tightness short of breath hives eczema dry skin
itchy skin sneezing watery eyes itchy eyes ear infections swellings
upper respiratory infections pneumonia swelling of eyes stomach pain
food allergy diarrhea insect sting allergy drug allergy snoring migraine
fatigue post nasal drip sinus headaches skin rashes hay fever sinusitis
Other: _____

Please circle all the things that may trigger symptoms:
smoke aerosols paint fumes dust odors cut grass plants soap
hot temperature cold air rain humidity wind weather changes
exercise infections colds excitement stress dog cat laughter
mold pollen leaves cosmetics dampness hay

Are you allergic to any medications? If so, please list the medication and a brief summary of the type of reaction:

_____

_____

Are there any foods that you suspect you are allergic to? List the food and a brief description of the type of reaction:

_____

_____

Have you had any hospitalizations or surgeries? List year, hospital, reason for stay and physician:

_____

_____

_____

Please turn this page over and complete the back

Do you have any of the following? Please mark (X) your answers and write any explanations in "comments".	Yes (now)	Yes (past)	comments
Ear, nose, throat trouble or nasal polyps			
Hearing loss, loss of taste, loss of smell			
Chronic or frequent colds			
Sinus or frequent sinus infections			
Hay fever (sneezing, watery eyes, itchy nose)			
Asthma or asthmatic bronchitis			
Pneumonia			
Shortness of breath or wheezing			
Pain or pressure in chest			
Chronic cough or bronchitis			
Skin disease, hives, eczema, psoriasis			
Swelling of eyelids, lips or body			
Frequent or severe headaches or migraine			
Eye trouble, including cataracts, glaucoma			
swollen or painful joints or arthritis			
AIDS or HIV positive			
Tuberculosis			
Heart disease (angina, heart failure)			
Frequent indigestion or ulcer disease			
Stomach, liver or intestinal trouble			
Urinary or bladder trouble			
Blood transfusion			
Tumor, growth, cancer			
Recreational drug use (marijuana, cocaine, etc)			
I may have a drinking problem			
High or low blood pressure			
Diabetes or thyroid disease			
Bee sting allergy			
Unusual stress at home or work			
Dizziness			
Nervous trouble, irritability, anxiety			
Depression			
Fatigue, extreme tiredness			
Inability to concentrate or loss of memory			
Recent loss of weight			

Patient Name _____ **Date** _____

Family History (known medical problems such as allergies, asthma, hay fever, heart disease, high blood pressure, sinus, headaches, etc. **Note if alive or not,** current age, or age of death and cause of death)

Mother: _____

Father: _____

Brother/Sister 1: _____

Brother/Sister 2: _____

Brother/Sister 3: _____

Child 1: _____

Child 2: _____

Child 3: _____

At Home:

About how old is your house/apartment? _____
How long have you lived in your house/apartment? _____
Is your house in a residential, country, or farm area? (circle)
Are there open fields less than 1/2 mile from your house? Yes / No
Is there water nearby the house like a lake, stream, or pond? Yes / No

What type of heating system do you have? Gas, forced air, oil, electric, wood, Other _____ (circle)
Do you have air conditioning? Yes / No Window unit or Central (circle)
Do you have an attic fan? Yes / No
Do you have a humidifier, either portable or attached to the furnace? Yes / No
Is the basement in your house dry or damp? (circle)
Do you use a vaporizer? Yes / No
Do you have an air cleaner? Yes / No Portable or central (circle)
Do you have any plants in the house? Yes / No

How many people smoke at home? _____
Is there smoking inside the house? Yes/ No
Are you (the patient) a smoker? Yes / No
How many years have you smoked? _____
How many packs of cigarettes do you smoke each day? _____

Do you have any pets? Yes / No cat_____ dog_____ bird _____ other _____
Are the pets ever inside the house? Yes / No
Do the pets come inside the home? Yes / No

Please turn this page over and complete the back

Bedroom:
What kinds of pillows are in the bedroom? Feather, Dacron, foam, unknown (circle)
Do you have a down quilt in the bedroom? Yes / No
Are the floors in the bedroom carpeted? Yes / No

MISC:
Is there any obvious mold growth/odors: home work school (circle)
Is there any obvious water damage or flooding: home work school (circle)
Is your home: dry average damp (circle)

Are there hobbies or work at home that use materials or chemicals that you might inhale or come in contact with? Please list and give details.

_____

_____

What do you do with your free time? (sports, hobbies, church work, choir, reading, gardening, crafts, etc.)

_____

_____

Work: (Skip this section if the patient is a child)
What type of work do you do? _____
Are there any smokers at work? Yes / No
Do you have exposure with any fumes or chemicals at work? Yes / No
List those that you know or suspect _____

_____

Is there adequate air ventilation at your work? Yes / No

Is there anything else you would like me to know about?
Are there any questions you might want to ask?

Thank you for filling out this form.

How did you find out about Dr. Loren?

Many of our patients are referred by friends, family members and physicians. Often patients hear about Dr. Loren through more than one source. It helps us if you can tell us how you found out about Dr. Loren.

Check off as many items that apply:

____ Family member

____ Friend

____ Doctor

____ Insurance plan list

____ Telephone yellow pages __Independence __ Lee's Summit __ Blue Springs

____ I saw him on television

____ Newspaper Ad ___ Examiner ___ Lee's Summit Journal

____ Newspaper article

____ I attended a talk he gave

____ Web page – What search engine did you use?_____

____ Other _____

Name of who referred you _____

Name of primary care doctor _____

MEDICATION SHEET

PATIENT NAME _____ DATE_____

LOCAL PHARMACY:_____

MAIL ORDER PHARMACY:_____

PLEASE LIST **ALL** MEDICATIONS, NASAL SPRAYS, INHALERS AND OVER THE COUNTER MEDICATIONS THAT YOU ARE CURRENTLY TAKING.

MEDICATION	DOSE AND FREQUENCY	FOR WHAT CONDITION
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		