

Initial Visit Form

Allergy, Asthma & Sinus Center of Long Island

Harshit M. Patel, M.D.

Tel#: (516) 822-6655 Fax #: (516) 932-2090

Name: _____

Appt Date: _____

Date of Birth: _____

To be completed by patient

Describe in your own words the reason for your visit:

Pharmacy Name:

Address/Town:

Phone Number:

Current Medications: Please list all medications that you are currently taking, including over-the-counter medications:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

Primary Physician: _____

Referred By: _____

To be completed by physician:

Chief Complaint:

History of Present Illness:

Associated Symptoms:

Nasal: ITCHY RUNNY CONGESTED SNEEZING
SNORING MOUTHBREATHER NOSEBLEEDS

Sinus: HEADACHE PRESSURE INFECTIONS

Ear: ITCHY POPPING OM TUBES HEARING LC

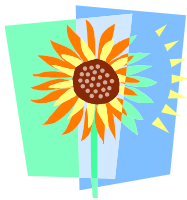
Eye: ITCHY RUNNY SWELLING REDNESS

Throat: ITCHY PND HOARSENESS STREP

Chest: COUGH WHEEZE TIGHTNESS SOB
BRONCHITIS PNEUMONIA

Skin: ITCHY HIVES ECZEMA

Other:



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To be completed by patient:

Medical History:

1. Have you ever had nasal or sinus surgery?
" Yes | " No Type:
2. Have you had a tonsillectomy or adenoidectomy?
" Yes | " No Type:
3. Have you ever had ear tubes?
" Yes | " No Dates:
4. Have you ever been tested for allergies?
" Yes | " No
If so, did you have Skin Tests of RAST (Blood) tests?
5. Have you ever had allergy injections?
" Yes | " No Dates:
Did they help?
6. List ALL drug allergies:
7. List ALL food allergies:

For children under 15, please complete the following:

1. Birth Weight:
2. Were there any complications following delivery?
" Yes | " No Explain:
3. Are immunizations up to date?
" Yes | " No

To be completed by physician: _____

Family History:

	Father	Mother	Sibs	Children
Asthma				
Allergies				
Hives				
Eczema				
Cancer				
Other				

Physical Exam:

WT: _____ HT: _____

T: _____ P: _____ BP: _____

General Appearance:

EYES: CONJUNCTIVA- NORMAL R L ; RED R L
LIDS- NORMAL R L ; EDEMA-

EARS: TMS- NORMAL R L ; DULL R L ; RED R L
CANALS- NORMAL OCCLUDED

NOSE: MUCOSA- NORMAL PALE RED
EDEMA- R- MILD MODERATE SEVERE
L- MILD MODERATE SEVERE
MUCOUS- MILD MODERATE COPIOUS
SEROUS WHITE MUCOID
POLYPS- NONE ; PRESENT R L
SEPTUM- MIDLINE ; DEVIATED R L
EXCORIATED R L ; PERFORATED

OROPHARYNX: PALATE- NORMAL OTHER:
POST PHARYNX- NORMAL INJECTED
COBBLESTONED PND

TEETH & GUMS: NORMAL ; OTHER:

FACE/SINUS TENDERNESS:

ABSENT FRONTAL MAX

NECK: NORMAL APPEARANCE

THYROID: NORMAL ENLARGED

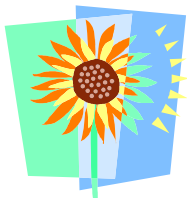
LYMPHATICS: NECK AXILLA GROIN

CHEST: VENTILATION- NORMAL RETRACTIONS

AUSCULTATION- NORMAL

WHEEZES R L BILAT FVC

RHONCHI R L BILAT



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To be completed by patient:

Check the following medical conditions that you have
Currently:

Asthma: ☐ Rhinitis ☐ Nasal ☐ Congestion ☐ Sore Throat
☐ Cough

Constitutional: ☐ Fever or Chills ☐ Fatigue

Heent: ☐ Eye Pain ☐ Blurry Vision ☐ Hoarseness

Respiratory: ☐ Cough ☐ Wheezing

Cardiovascular: ☐ Chest Pain ☐ Palpitations

Gastrointestinal: ☐ Nausea ☐ Vomiting

Urology: ☐ Dysuria ☐ Urinary Frequency

Musculoskeletal: ☐ Joint Stiffness ☐ Muscle Pain

Dermatology: ☐ Eczema ☐ Hives

Neurology: ☐ Weakness ☐ Headache

Hematology: ☐ Fatigue ☐ Swollen Glands

Endocrine: ☐ Weight Fluctuations ☐ Heat Intolerance
☐ Cold Intolerance

Psychology: ☐ Anxiety ☐ Depression

Please list all hospitalizations (including year and reason).

- 1.
- 2.
- 3.

Social History:

Current Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Hobbies: _____

Cigarette Smoking History: _____

Alcohol Use History: _____

How many drinks per day? (Circle one) 1 3 5+

Other: _____

Environmental History (Please Check the appropriate boxes):

Home: ☐ House ☐ Apartment ☐ Condo
☐ Mobile Home Age: _____

Pets: ☐ Cat ☐ Indoor ☐ Outdoor
☐ Dog ☐ Indoor ☐ Outdoor

Smokers: ☐ None
☐ Indoors By: _____
☐ Outdoors By: _____

Heat: ☐ Central ☐ Radiator

Air conditioning: ☐ Central ☐ Window

Pillows: ☐ Feather ☐ Non-feather Age: _____

Bed: ☐ Mattress/Boxspring ☐ Waterbed
Age: _____

Flooring: ☐ Hardwood ☐ Carpet Age: _____

Basement or Crawl space:
☐ Dry ☐ Damp ☐ Musty

Patient: _____

Appt Date: _____

Physical Exam (Continued)

CVS: * Heart-

*PV (Observ/Palp)-

Abdomen: *Tenderness Mass-

* Liver/Spleen Normal Enlarged

Extremities:

Skin: Normal Other:

Neuro/Psych: *Orientation-

*Mood/Affect-

Other:

Labs/X-Ray:

Assessment/Plan:

1.

2.

3.

RTC: _____

By: _____