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 L(

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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Name: _____

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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: CONJUNTIVA- 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 Crawlspace: ☐ 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: _____