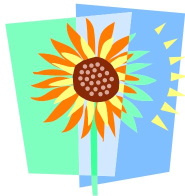


Initial Visit Form

Harshit Patel, M.D.
120 Bethpage Road, Suite 310
Hicksville, NY 11801
(516) 822-6655

Name: ____________________________

Appt Date________________________

Date of Birth: ____________________

To be completed by patient.

Describe in your own words the reason for this visit:

____

____

____

____

____

____

____

____

____

____

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.
10.
11.
12.

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(

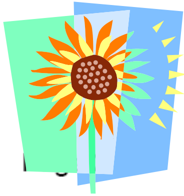
Eye: ITCHY RUNNY SWELLING REDNESS

Throat: ITCHY PND HOARSENESS STREP

Chest: COUGH WHEEZE TIGHTNESS SOB
BRONCHITIS PNEUMONIA

Skin: ITCHY HIVES ECZEMA

Other:



Initial Visit Form

Harshit Patel, M.D.
120 Bethpage Road, Suite 310
Hicksville, NY 11801
(516) 822-6655

Name: ______________________________

Appt Date_________________________

To be completed by patient.

Medical History:

1. Have you ever had nasal or sinus surgery?
   ☐ Yes ☐ No
   Type:

   Date(s):

2. Have you had a tonsillectomy or adnoidectomy?
   ☐ Yes ☐ No

   Date(s):

3. Have you had ear tubes?
   ☐ Yes ☐ No

   Date(s):

4. Have you ever been tested for allergy?
   ☐ Yes ☐ No
   If so, did you have skin tests or RAST(blood) tests?
   ☐ Yes ☐ No
5. Have you ever had allergy injections?
   ☐ Yes ☐ No
   If so, please give dates:

   Did they help?

6. List all drug allergies:

7. List all food allergies:

8. Have you ever had a severe reaction to a bee string or ant bite? ☐ Yes ☐ No

   Describe:

For children under 15, complete the following:

1. Birth Weight:
2. Were there any complications following delivery? ☐ Yes ☐ No
   Explain:

3. Has growth and development been normal? ☐ Yes ☐ No
   Explain:

4. 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

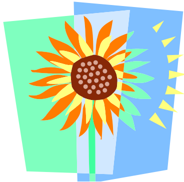
NECK: NORMAL APPEARANCE

THYROID: NORMAL ENLARGED

LYMPHATICS: NECK AXILLA GROIN

CHEST: VENTILATION- NORMAL RETRACTIONS

AUSCULTATION- NORMAL
WHEEZES R L BILAT FVC
RHONCHI R L BILAT



Initial Visit Form

Harshit Patel, M.D.
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Hicksville, NY 11801
(516) 822-6655

To be completed by patient.

Check the following medical conditions that you have currently or have had in the past.

	Current	Past
Eye Disease	☐	☐
Nasal Polyps	☐	☐
Emphysema	☐	☐
Croup	☐	☐
Heart Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Gastroesphageal Reflux	☐	☐
Ulcers	☐	☐
Colitis or Diverticulitis	☐	☐
Bladder Infections	☐	☐
Prostate Problems	☐	☐
Arthritis	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Depression	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Other: ____________	☐	☐

____
____

Please list all hospitalizations (including year and reason)

1.

2.

3.

Social History

Current Occupation: ______________________

Marital Status: **S M D W**

Hobbies:

____
____
____

Cigarette Smoking History:

____

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 ________________________

To be completed by physician.

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)

4)

RTC ____________

By: ____________________