Staple

BRIGHAM HEALTH

BRIGHAM AND WOMEN'S HOSPITAL

PATIENT IDENTIFICATION AREA

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Demographic Data

Patient Name: DOB: Date:

Address:

Occupation:

Telephone Number Home: Work: Cell:

Emergency Contact:

Relation: Telephone:

Address:

Referring Physician:

Address:

Telephone:

ALL PATIENTS MUST BRING AN UP-TO-DATE AND ACCURATE LIST OF ALL MEDICATIONS THEY ARE CURRENTLY USING OR HAVE TAKEN IN THE PAST 6 MONTHS (including dosages)***

Demographic Data

Age: Weight: Height: Occupation:

Please list the main reasons for your visit today:

Do you have any of the following systems? (Circle)

sneezing	blocked nose	watery nose	shortness of breath
wheezing	chest tightness	cough	sputum (phlegm)
night symptoms	severe itching	severe swelling	acid stomach

Have you been told or think you have any of the following? (Circle)

sinusitis	ear infections	nasal polyps	recurrent bronchitis
eczema	hives	stomach reflux	allergic rhinitis / hay fever
diabetes	tuberculosis	frequent infection	high blood pressure

Which of the following bring on attacks of allergies and asthma? (Circle)

respiratory infection	cold air	Allergens:
occupation chemicals	exercise	pollens
emotions-stress	weather changes	dust
tobacco-smoke	strong odors	mold
Other triggers: _____		dog
_____		cat
_____		

What months are your symptoms worse? (Circle)

Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. None

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Symptoms worsen: (Circle)

At night Mornings Evenings At home At work Indoors Outdoors

Other Allergies? (List)

Medications:

Foods/Food additives:

Insects (Describe reaction):

Latex (rubber products):

Hobbies: Indoor: Outdoor:

History of any prior Allergy evaluations? Yes No

If so, when and where:

Skin test results:

Previous Allergy Injections? Yes No Dates

Current medications: (please list medication and dose):

*** A reminder to please bring a list of medications prescribed by your allergist

Smoking: Do you smoke? Yes No Date stopped

Number of years smoked? Approximate number packs/day

Family History

Allergy in close relatives: Yes No List them:

Asthma in close relatives: Yes No List them:

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Environmental History

How long in current home? Apt. How old?

Location: City Suburb Rural

Is there a basement? (circle damp or dry)

What kind of heating system? Radiator/baseboard Hot air

Bedroom: What floor is bedroom on? Bedroom carpeted?

Type of pillow: Type of comforter: Any Down Y or N

Mattress: Inner spring Futon Water Foam

Do you have allergy-proof covers for your pillows? Mattress?

Flooring: Hard Wood: Area rug: Wall to Wall:

Air conditioning: Central Separate units Humidifier:

Animals in home: Yes No List:

Tobacco smoke in home? Yes No Who?

If you suspect you have asthma, please answer the following

Nighttime wheezing, cough, shortness of breath:

Often Occasional Never

Limitations and symptoms: With sports or strenuous exercise:

With any activity: Symptoms are present at rest

Number if school/work days missed during last year (appropriate)

Number of oral steroid (prednisone) prescriptions in last year (Approximate):

Number of visits for asthma (lifetime) to emergency room:

History of "Life threatening" attacks? Yes No Intubated: Yes No

Have you had any other serious illness, accidents, or hospitalizations?

If so, when?

Are you pregnant or planning on getting pregnant?

Please list any questions/concerns that you would like discussed during this visit and list what you would like to accomplish with today's visit?

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Have you (or child for whom you are filling out this form) ever felt unsafe or been afraid of anyone (i.e. your partners, a relative, or anyone else?

Do you experience pain as part of your daily life?

If yes, describe the location(s); onset; durations; and characteristics of your pain (i.e. ache, burn, throb, sharp).

If yes, on a scale from 1-10, 10 being the greatest pain, how would you describe this pain?

If yes, how do you treat your pain?

Do you have a Health Care Proxy, Advance Directive or Living Will?

If yes, please identify:

Reviewed by:

Date_____ Time _____ Physician _____ MD CID

Demographic Data

REVIEW OF SYSTEMS

IN THE LAST **12 MONTHS**, HAVE YOU HAD ANY OF THE FOLLOWING:

GENERAL	Yes	No
Fevers		
Chills		
Large Weight Change		
Enlarged Lymph Nodes		
EYES		
Itchy Watery Eyes		
Red Eyes		
Blurry Vision		
EAR/NOSE/THROAT		
Ear popping		
Difficulty hearing		
Post-nasal drip		
Sinus pain/pressure		
CARDIOVASCULAR		
Heart palpitations		
Abnormal heart rhythm		
Chest pain		
Swollen ankles		
RESPIRATORY		
Shortness of breath		
Chronic cough		
Wheezing		
Chest Tightness		
GASTROINTESTINAL		
Heartburn/reflux		
Nausea/vomiting		
Diarrhea		

BONES/JOINTS	Yes	No
Painful joints		
Back pain		
SKIN		
Eczema		
Dry skin		
Sensitive skin		
Hives		
Rashes		
GENITOURINARY		
Frequent urination		
Pain with urination		
Abnormal menses (women)		
ENDOCRINE		
Heat Intolerance		
Cold Intolerance		
Excess thirst		
NEUROLOGICAL		
Fainting spells		
Dizziness		
Seizures		
PSYCHOLOGICAL		
Increased stress		
Depression		
Anxiety		
Suicidal thought		
OTHER		

Reviewed by:

Date_____ Time _____ Physician _____ MD CID | | | | | |

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Did you receive a copy of the "We Care About Your Safety" brochure? ❒ Yes ❒ No

Do you understand how to prevent the spread of germs? ❒ Yes ❒ No

Reviewed by:

Date_____ Time _____ Physician _____ MD CID | | | | | |

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