ROCKY MOUNTAIN ALLERGY • ASTHMA IMMUNOLOGY at Tanner Clinic

Be aware that submission through electronic means may not be secure. Faxing is more secure than emailing.

2121 North 1700 West
Layton, UT 84041
Ph 801.773.4840
Fax 801.525.8179

5296 S Commerce St.
Suite 104
Murray, UT 84107
Ph 385.261.2410
Fax 385-261.2404

Instructions: Please answer the following questions as completely and accurately as possible. The parent should fill out the form for patients under the age of 15.

NEW PATIENT QUESTIONNAIRE

Today's Date _____

Patient's Name _____ DOB _____ Sex: M F

How did you hear about our clinic or who were you referred by? _____

Reason for Allergy visit (briefly describe): _____

_____

A. Please check the conditions that have bothered you in the last 12 months:

Nose:
___ Stuffy
___ Sneezing
___ Itching
___ Draining
___ Bleeding
___ Mouth breathing
___ Snoring
___ Loss of smell
___ Frequent sinus infections

Eyes:
___ Itching
___Burning
___Watering
___ Swelling

Throat:
___ Itching
___ Draining
___ Throat clearing
___ Soreness
___ Hoarseness
___ Loss of Taste

Ears:
___ Itching
___ Popping
___ Draining
___ Ringing
___ Hearing Loss
___ Fluid behind eardrums
___ Frequent ear infections

Respiratory:
___ Cough
___ Wheeze
___ Shortness of Breath
___Tightness
___ Phlegm (mucus)
___ Bronchitis
___ Pneumonia

Gastrointestinal
___ Abdominal pain
___ Vomiting
___ Diarrhea
___ Constipation
___ Poor appetite
___ Poor weight gain
___ Heartburn/acid reflux

Nervous System:
___ Headache
___ Unusual tiredness
___ Irritability

Skin:
___ Hives
___ Itch
___ Swelling

Musculoskeletal:
___ Muscle pains
___ Joint pains

Cardiovascular:
___ Heart racing
___ Chest pain

Constitutional:
___ Fevers

Allergy:
___ Food allergy

Endocrine:
___ Heat/cold intolerance

Other symptoms not listed above: _____

_____

_____

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History of Present Illness:	Nose/Eye	Chest	Skin
When did these symptoms begin (year)?	_____	_____	_____
Where did these symptoms begin (state)?	_____	_____	_____
When did these symptoms occur last (date)?	_____	_____	_____
What time of day are these symptoms worse?	_____	_____	_____

Underline the month(s) your symptoms occur. Circle the months that are worst.

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

B. What medications or treatments have you taken in the past for your allergies and/or asthma?

		Helpful? Yes	No			Helpful? Yes	No
1.	_____	___	___	5.	_____	___	___
2.	_____	___	___	6.	_____	___	___
3.	_____	___	___	7.	_____	___	___
4.	_____	___	___	8.	_____	___	___

C. Please list all your current medications and reasons for taking them:

_____

_____

_____

_____

_____

_____

_____

_____

D. Have you ever been on allergy shots (immunotherapy)? If yes, when, for how long, and to what?

_____

_____

Past Medical History

E. Please list any medication allergies including a description of any reactions:

_____

_____

_____

F. Please list any past or current medical problems not yet mentioned above, including any surgeries:

_____

_____

_____

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G. Please list any medical problems that run in your immediate family:

Relationship (mother, brother, daughter, etc.)

Asthma: _____
Hay Fever or Allergic Rhinitis: _____
Eczema: _____
Immunodeficiency of any type: _____

Any other medical problems in the family:

_____ _____
_____ _____
_____ _____

H. Personal History:

Do you smoke? _____ How many packs per day? _____ How Long have you smoked? _____

Does anyone smoke at home or work? _____

Do you have any pets? If yes, type (cat, dog, etc.) and number.

_____

What is your occupation? _____

What is your exercise routine? _____

If the patient is a young child, does he/she attend daycare? _____

Signature _____ Date _____

Rocky Mountain Allergy + Asthma Immunology

Patient Medical History Form

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Please fill out every space. If it does not pertain to you, please write N/A for "Not Applicable"

Patient Information

Last Name	First Name	M. Initial	DOB	Gender
				☐ M ☐ F

Mailing Address	City	State	Zip

Home Phone #	Cell Phone #	Work Phone #	Social Security #

Employer Name and Address	Email Address

Marital Status	Spouse's Name	Spouse's DOB	Spouses Phone #

Race
☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Ethnicity - ***Race/Ethnicity Questions are asked in order to identify additional care needs of our diverse patients. No discrimination intended***
☐ Caucasian ☐ Hispanic ☐ African American ☐ Pacific Islander ☐ American Indian/Alaska Native ☐ Asian

How did you hear about our Practice?
☐ Facebook ☐ Good 4 Utah ☐ Health Fair ☐ Insurance ☐ Internet Search ☐ KUTV ☐ Ogden Marathon ☐ Radio ☐ Seminar ☐ Twitter ☐ KSL
☐ Another Patient (Name): ☐ Other:
☐ Referring Provider: Provider Name Provider Ph # Facility

Responsible Party

☐ Self ☐ Mother ☐ Father ☐ Other:	Last Name (If not Patient)	First Name	DOB	Gender ☐ M ☐ F

Address	City	State	Zip

Primary Phone #	Social Security #	Employer	Business Phone #

Parent/Guardian Information (Fill out if patient is under 18 yrs of age)

☐ Mother ☐ Father ☐ Other:	First & Last Name	Phone Number

☐ Mother ☐ Father ☐ Other:	First & Last Name	Phone Number

Insurance Information

Primary Insurance: Name & Address	ID #	Group #

Policy Holder Name	Policy Holder DOB	Social Security #	Effective Date

Policy Holder Address	Policy Holder Phone #	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other:

Secondary Insurance: Name & Address	ID #	Group #

Policy Holder Name	Policy Holder DOB	Social Security #	Effective Date

Policy Holder Address	Policy Holder Phone #	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other:

Emergency Contact

First & Last Name	Phone #	Relationship to Patient

If this visit is due to an accident, please provide the information here: ☐ Auto ☐ Industrial

Details:

Consent to Treat and to Disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above-named patient to administer anesthetics and/or medications and to perform such oeprations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclose of protected health information for treatment, payment, and health care operations. Patients injured at work typically obtain information through their adjuster or employer. I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy notice, my consent to treatment, and the above-listed uses of protected health information.

Signature of Patient/Responsible Party **Date**