Northeast Georgia
PHYSICIANS GROUP

Andy Nish, M.D. Kimberley Shanks, M.D.

Patient History Form Date:____________________

Patient Name:______________________________ Primary Physician:____________________________
Age:______ DOB: ____________ Who Referred you to us?_________________________________
Main reason you are here:____

On all sections; please circle any symptoms you are having or have had.

○ Nasal / Sinus Symptoms

☐ Check here if you have no Nasal or Sinus symptoms and move to the next section

How long have you had nasal or sinus symptoms? ______ weeks ______ months ______ years
Nasal congestion
Runny nose, what color if any _______________________
Sneezing: Yes / No
Please circle your worst season(s)? spring summer fall winter year round
Itchy nose, throat or ears
Itchy watery eyes
Post nasal sinus drainage, what color if any ________________________
Sinus headaches, where ___________________________
Nosebleeds
Bad breath or bad taste in mouth ______occasionally ______frequently ______constantly
Sinus infections, how often? _____________________________
Popping in ears
Have you had any sinus x-rays or CT scans? Yes / No; if Yes, when and what were results?
____
Medicines tried and did they help?____
Symptoms worsened by?____
Have you been seen by an Allergist in the past? (when, results)_____________________________

○ Chest and Lungs

☐ Check here if you have no Chest or Lung symptoms and move to the next section

When did your chest or lung symptoms start?____
Shortness of breath
Chest tightness
"Rattles" in chest
Wheezing
Cough, if Yes; worse day, night or both
Sputum coughed up, Yes / No; if Yes, color:______________________________
Chest symptoms worsened by (circle) viruses, cigarette smoke, exercise / running, temperature changes, weather changes, strong odors, chemicals, laughter, emotional upset
Have you ever been diagnosed with asthma? Yes / No; if Yes, when:____________________

Do these symptoms awaken you at night or keep you from sleeping? Yes / No; How often?___________
Do symptoms limit your daily activities? Yes / No
Do symptoms limit your exercise? Yes / No
Have you ever been hospitalized for chest and lung symptoms? Yes / No
How many times?______________ Last time?________________
Have you been treated in the ER for these symptoms? Yes / No
How many times?______________ Last time?________________
Are there any medicines that you have tried, other than what you are currently on, for these symptoms?
____

○ Stomach

Do you have heartburn? Yes / No Frequent burping? Yes / No; How often?_______________
Do you have chronic diarrhea? Yes / No
If a child, has growth been normal? Yes / No

○ Other Allergies

Eczema: Yes / No; if Yes, please explain:____
____
Hives: Yes / No; if Yes, please explain:____
____
Other rashes: Yes / No; if Yes, please explain:____
____
Reaction to Foods: Yes / No; if Yes, please list the food(s) and the reaction:_________________________
____
Reaction to Medicine: Yes / No; if Yes, please list the medicine and the reaction:___________________
____
Reaction to Insects: Yes / No; if Yes, please list the insect and the reaction:________________________
____

○ Past Medical History

Do you have any long term medical problems? Yes / No; if Yes, please explain:____________________
____
____
Have you ever had surgery? Yes / No; if Yes, please list the surgery and when:______________________
____
Any hospitalizations? Yes / No; if Yes, please list what hospitalizations was for and when:____________
____
**All medications currently taking, including over the counter medication and how often taken:________
____
____
____
Are your immunizations up to date? Yes / No

Patient Name:____ DOB:______________

○ Environmental History

How long have you lived at your current home? _____________________

Is it a house, apartment, mobile home? How old?_____________________

It is made of: brick, wood, siding, block, other:________________________

Type of bed mattress: foam, inner spring, waterbed

Type of pillow: foam, feather, other:______________________________

Floors are: carpet, wood, linoleum, tile, other:_______________________________

Air conditioning: none, window unit, central

Heat: electric, gas, wood, oil, kerosene

Basement: none, dry, damp, very wet

Heat / air filters changed every __________ months

Any pets? Yes / No; if Yes, please list below:

Indoor pets______________________________ Outdoor pets_____________________________

Any smokers living there? Yes / No; Who?_________________________ Smokes indoors or outdoors?

How many people live there?___________________

Anything unusual or remarkable about this home?____

○ Family History

List allergies, asthma, eczema and related problems such as sinus problems:

Father: Yes No N/A If Yes, please explain:_____________________________________

____

Mother: Yes No N/A If Yes, please explain:_____________________________________

____

Brother: Yes No N/A If Yes, please explain:_____________________________________

____

Sister: Yes No N/A If Yes, please explain:_____________________________________

____

Sons: Yes No N/A If Yes, please explain:_____________________________________

____

Daughters: Yes No N/A If Yes, please explain:_____________________________________

____

○ Social History

Occupation (if retired, previous work):____

Work environment:____

If student, what school and grade?____

Tobacco use: None, Smoking Now, or Quit in ____________________

If you ever smoked, _________packs per day for ___________years

Hobbies:____

Anything else you would like to discuss?