

**PATIENT INFORMATION**

Thank you for choosing our office! In order to serve you properly, we need the following information.  
 Please print. All information will be confidential.

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_  
 SSN: \_\_\_\_\_  Male  Female Birth date: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated  
 Patient's or parent's employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Spouse's or parent's name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 If patient is a student, name of school/college: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Whom may we thank for referring you?: \_\_\_\_\_  
 Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**Responsible Party**

Name of person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Driver's license #: \_\_\_\_\_ Birth date: \_\_\_\_\_ Financial Institute: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Is this person currently a patient at our office?  Yes  No

**Insurance Information**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Social security number: \_\_\_\_\_ Date employed: \_\_\_\_\_  
 Name of employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Address of employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_ Union or local #: \_\_\_\_\_  
 Ins. co. address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

**Do you have any additional insurance? Yes No If yes, complete the following:**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Social security number: \_\_\_\_\_ Date employed: \_\_\_\_\_  
 Name of employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Address of employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_ Union or local #: \_\_\_\_\_  
 Ins. co. address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

\_\_\_\_\_  
 Signature of patient or parent if minor \_\_\_\_\_  
 Date

# Allergy, Asthma AND IMMUNOLOGY

*Advanced, personalized care for effective relief*

## Patient History

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

Reason for seeing the doctor: \_\_\_\_\_

Current medications: \_\_\_\_\_

## Personal History: (age at onset)

Asthma: \_\_\_\_\_

Ear Infection: \_\_\_\_\_

Colic: \_\_\_\_\_

Bronchitis: \_\_\_\_\_

Throat infection: \_\_\_\_\_

Eczema: \_\_\_\_\_

Sinus problems: \_\_\_\_\_

Hives: \_\_\_\_\_

Hay fever: \_\_\_\_\_

Diarrhea: \_\_\_\_\_

Rashes: \_\_\_\_\_

Coughing: \_\_\_\_\_

Nausea: \_\_\_\_\_

Headaches: \_\_\_\_\_

Sneezing: \_\_\_\_\_

Stomach problems: \_\_\_\_\_

Other: \_\_\_\_\_

**Worst Season:** Winter - Spring - Summer - Fall - All Year

**Circle if worse:** After eating - Exertion - Indoor - Outdoor - Work - Home - School  
Morning - Day - Night - Changes in the weather - Air conditioning

**Aggravating Factors:** Dust - Dog - Cat - Feathers - Hay - Barn - Cattle - Horses - Fur  
Wool - Odors - Tobacco - Colds - Cosmetics - Smoke - Leaves - Mowing

**Pollens:** \_\_\_\_\_ **Flowers:** \_\_\_\_\_ **Plants:** \_\_\_\_\_ **Foods:** \_\_\_\_\_

**Allergy to insects:** Mosquito - Bee - Wasp - Other: \_\_\_\_\_

**Allergy to medicines:** Aspirin - Penicillin - Sulfas - Mycins - Tetanus - Other: \_\_\_\_\_

**Serous illnesses:** \_\_\_\_\_

**Date of last Chest X-ray:** \_\_\_\_\_

**Previous surgery:** Tonsils - Adenoids **Date:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

Nose - Polyps - Sinuses - Ear Tubes **Date:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

Other: \_\_\_\_\_

**Previous allergy testing date:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Treatment:** \_\_\_\_\_ **How long:** \_\_\_\_\_

## Family History

**Does any member of the family have:** Allergies - Asthma - Hay fever - Rashes - Hives

**Which family member:** Father - Mother - Brother - Sister - Uncle - Aunt - Grandparent

## Living Conditions

**Type of setting:** City - Country **Basement:** Damp - Dry **Bathroom:** Bathtub - Shower - Carpet

**House:** Brick - Frame - Trailer - Apartment **Bedrooms:** Pillows - Feather - Dacron - Foam - Plastic-covered

**Mattress:** Innerspring - Foam - Cotton - Feather **Windows:** Curtains - Drapes - Blinds

**Type of Heating:** Gas - Electric - Coal - Wood - Other: \_\_\_\_\_ **Floors:** Carpet - Linoleum - Tile - Hardwood

**Air Conditioning:** None - Central - Window **Any stuffed toys:** \_\_\_\_\_

**Pets:** Cat - Dog - Bird - Indoor - Outdoor **Animals:** Horse - Cattle - Rabbits - Other: \_\_\_\_\_

**Any exposure to cigarette or pipe smoke?** Yes No

# Allergy, Asthma AND IMMUNOLOGY

*Advanced, personalized care for effective relief*

## ALLERGY, ASTHMA AND IMMUNOLOGY, P.S.C.

Iraklis C. Livas, MD  
1019 Majestic Drive, Suite 210  
Lexington, KY 40513  
(859) 277-3114  
(800) 640-0246

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

### REVIEW OF SYSTEMS

<p><b>CONSTITUTINAL SYMPTOMS</b></p> <p>Good health lately..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Recent weight change..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Fever..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Fatigue..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>EYES</b></p> <p>Eye disease or injury..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Wear glasses/contact lenses..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Blurred or double vision..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Glaucoma..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>EAR/NOSE/MOUTH/THROAT</b></p> <p>Hearing loss or ringing..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Earaches or drainage..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Chronic sinus problem or rhinitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Nose bleeds..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Mouth sores..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Bleeding gums..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Bad breath or bad taste..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Sore throat or voice change..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Swollen glands in neck..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>CARDIOVASCULAR</b></p> <p>Heart trouble..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Chest pain or angina pectoris..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Palpitation..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Shortness of breath w/ walking or lying flat..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Swelling of feet, ankles or hands..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>RESPIRATORY</b></p> <p>Chronic or frequent coughs..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Spitting up blood..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Shortness of breath..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Asthma or wheezing..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><b>GASTROINTESTINAL</b></p> <p>Nausea or vomiting..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Frequent diarrhea..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Painful bowel movements or constipation..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Rectal bleeding or blood in stool..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Abdominal pain or heartburn..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Peptic ulcer (stomach or duodenal)..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>GENITOURINARY</b></p> <p>Frequent urination..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Burning or painful urination..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Blood in urine..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>MUSCULOSKELETAL</b></p> <p>Joint pain..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Joint stiffness or swelling..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Back pain..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>INTEGUMENTARY</b></p> <p>Rash or itching..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Varicose veins..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>NEUROLOGICAL</b></p> <p>Frequent or recurring headaches..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Lightheaded or dizzy..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Convulsions or seizures..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>PSYCHIATRIC</b></p> <p>Nervousness..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Depression..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Insomnia..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>ENDOCRINE</b></p> <p>Glandular or hormone problem..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Thyroid disease..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Diabetes..... <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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