Pediatric and Adult Asthma, Allergy & Immunology

New Patient Forms

PLEASE READ

Completing these forms in advance of your visit can save you significant time in the waiting room and during your visit.

It is important that you use **BLACK INK.**

If your insurance requires that you obtain a referral from your primary physician prior to seeing a specialist, it is mandatory that we have the referral at the time of your visit. Otherwise, your visit will need to be rescheduled.

Lisa Barisciano, MD
Pediatric and Adult Asthma, Allergy & Immunology, LLC
15 James Street
Florham Park, NJ 07932
P 973 503 0600
F 973 503 0424
www.hanoverallergy.com

Lisa Barisciano, M.D.
Pediatric and Adult Asthma, Allergy & Immunology

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Florham Park, NJ 07932
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NEW PATIENT QUESTIONNAIRE

Please answer all the questions that apply to you or your child (hereafter referred to as "you") and bring this form with you on the day of your visit.

PATIENT'S NAME:	**DATE OF BIRTH:**
REFERRED TO THIS OFFICE BY:	**PRIMARY CARE PHYSICIAN:** **ADDRESS:** **PHONE:**

1. **CHIEF COMPLAINT** *(Reason for Visit)*: ____

____

____

2. **HISTORY OF PRESENT ILLNESS** (**PHYSICIAN TO COMPLETE**): ____________________

____

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____

____

____

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____

____

____

3. **REVIEW OF SYSTEMS (PROBLEMS):** *Have you had any of the following symptoms or conditions? Check all that apply.*

System	***No***	***Yes***	***Check all that apply***	***Age of onset***	***All-year or seasonal?***	***Indoor or outdoor?***	***Comments***
Eyes			[ ] red, [ ] watery, [ ] itchy, [ ] swollen, [ ] mucus discharge [ ] light hurts eyes				
Ears			[ ] itchy, [ ] frequent infections (#__/yr)				
Nose			[ ] stuffy, [ ] itchy, [ ] sneezing, [ ] runny, _____ color, [ ] snoring, [ ] mouth breathing				
Sinus			[ ] frequent sinus infections (#___) [ ] thick discharge, yellow/green [ ] headaches				
Throat			[ ] post nasal drip, [ ] sore, [ ] itchiness, [ ] throat clearing, [ ] difficulty swallowing				
Chest			[ ] cough, [ ] wheezing, [ ] shortness of breath, [ ] bronchitis, [ ] pneumonias				

System	*No*	*Yes*	*Check all that apply*	*Age of onset*	*All-year or seasonal?*	*Indoor or outdoor?*	*Comments*
Abd/GI			[ ] frequent diarrhea, [ ]vomiting [ ] reflux, [ ] food allergies				
Skin			[ ] eczema, [ ] hives, [ ] dry skin, [ ] dry patches, [ ] frequent infections				
General			[ ] weight loss [ ] failure to gain weight				
Other			[ ] other infections requiring antibiotic therapy				

4. DIETARY HISTORY/FOOD REACTIONS:

- *If patient is a child, is or was the patient exclusively breastfed?* ______________________________
  for how long? ______________________________
- *When was formula introduced?* ____
  Which formula? ____
  Reactions? ____
- *Do you have any special diet?* ____
- *Are you avoiding any foods?* ____

FOOD	AGE	SYMPTOMS/REACTIONS	STILL AVOIDING?

5. PRECIPITATING FACTORS/TRIGGERS: *Please check boxes*

	Yes	No		Yes	No
Tree exposure			Tobacco smoke		
Grass Exposure			Exercise		
Raking leaves/mowing lawns			Animals (cats, dogs, etc.)		
Damp areas with mold and mildew			Cold or hot water		
Sweeping, dusting, vacuuming			Colds (upper respiratory infections)		
Smog/air pollution			Cleaning agents, fumes, perfumes		
Aspirin/Ibuprofen/other drugs			Menstrual periods		
Nighttime			Insect stings		
Temperature changes (hot/cold)			Others:		
Itchy lips/throat after eating bananas, melons, peaches, apples, kiwi, pears, citrus, shellfish, peanuts, or tree nuts					

6. PREVIOUS ALLERGY EVALUATION AND TREATMENT:

- *Have you ever had allergy skin testing?* ☐*Yes* ☐*No* *Date:* _______ *Physician:* ____________
  Results: ____
- *Have you ever had **RAST** testing (blood test)?* ☐*Yes* ☐*No* *Date:* _______ *Physician:* __________
  Results: ____
- *Have you ever received immunotherapy (allergy shots)?* ☐*Yes* ☐*No*
  Date: _______ *Physician:* ____________

- *Have you ever used:*
  [ ] Nasal Sprays: [ ]Rhinacort [ ]Flonase [ ]Nasonex
  [ ] Inhalers: [ ]Proventil/albuterol [ ]Flovent [ ]Pulmicort [ ]Advair [ ]Maxair [ ]Intal
  [ ] Medications: [ ]Singular [ ]Claritin [ ]Allegra [ ]Benedryl [ ]Atarax [ ]Prednisone [ ] Prelone

7. **PAST MEDICAL/SURGICAL HISTORY**: *Have you ever had any of the following conditions?*

List other medical illnesses:	**ER/Hospitalizations?** When/why	**Any surgeries?**
______________________ ______________________ ______________________ ______________________ ______________________ [ ] Cough up blood [ ] Tuberculosis [ ] Glaucoma [ ] Kidney problems [ ] Snoring/mouth breathing [ ] Diabetes	______________________ ______________________ ______________________ ______________________ **Abnormal tests?** [ ] Chest XR, when ______ [ ] CT scan	______________________ ______________________ ______________________ [ ] Tonsils/adenoids removed, if yes, when? ________ [ ] Sinus surgery? [ ] Myringotomy (tubes in ears)?

8. **MEDICATIONS**: *Do you take any medications currently? Please list all medications and dosages.*
____
____
____
____

9. **ALLERGIES:** *Do you have any known allergies to medications, foods, or drugs? If so, what was your reaction?* ____
____
____

10. **FAMILY HISTORY:**

Mother's health ______________________ age______ Father's health ______________________ age______
Brother(s) health ______________________ age______ Sister(s) health ______________________ age______

Do any family members have a history of allergic or immunologic conditions? If yes, please complete all that applies.

ALLERGY/DISEASE	YES	NO	LIST RELATIVES (INDICATE IF OUTGROWN AND WHEN)
Asthma			
Frequent bronchitis			
Frequent pneumonias			
Cystic fibrosis or other lung disease			
Hay fever / allergic rhinitis			
Chronic sinus problems			
Hives / urticaria			
Eczema			
Insect allergy			
Drug allergy			
Food allergy			
Immune disorder			
Autoimmune disorder (lupus, thyroid disease, rheumatoid arthritis)			
Early unexplained death in infancy			
Other			

11. **ENVIRONMENT/HOME SURVEY**: *List city and states where you have lived, with most recent first.*

	City	State	Years	Effects on symptoms, better/worse/no change
1.				
2.				
3.				
4.				

- Approximately how old is your home? __________
- How long have you lived there? __________
- Is your home a **[ ]**single family home, **[ ]**brownstone/townhouse, **[ ]**apartment?
- Does it have **[ ]**central air conditioning, **[ ]**central or forced hot air, **[ ]**radiator heat, **[ ]**baseboard, **[ ]**window air conditioning, **[ ]**humidifier, **[ ]**damp areas, **[ ]**basement, **[ ]**visible mold, **[ ]**cockroaches, **[ ]**smokers?
- Does your bedroom have **[ ]**wall-to-wall carpeting, **[ ]**hardwood flooring, **[ ]** area rugs, **[ ]**down pillows and/or comforter, **[ ]**stuffed toys?
- Does your bedroom have **[ ]**dust mite proof pillow and/or mattress covers, **[ ]**HEPA filter, **[ ]**weekly washing of bed linens?
- Please list all fur-bearing pets (cats, dogs, birds, gerbils, hamsters, etc.)
  ____
- Do the pets enter your bedroom? __________bed? __________
- Is there any location where your symptoms are worse? __________
- What is your occupation? __________ Are your symptoms worse at work? ________
- How many days form school or work have you missed because of your asthma or allergies? __
- Smoke exposure: ☐ **Yes** ☐ **No** Where? __________________________

12. **IMMUNIZATIONS**: *Please list vaccinations which you have received within the last 5 years.*

____
____
____

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□ New □ Update Information Name of Primary Physician:	Referring Physician:

PATIENT NAME (Last, First, MI)			DATE OF BIRTH		TELEPHONE (HOME)
E-MAIL Address					TELEPHONE (Work)
ADDRESS (Street, Apt #)					TELEPHONE (Mobile or Other)
CITY	STATE	ZIP	MARITAL STATUS		AGE
SEX (circle) Male Female	SOCIAL SECURITY NUMBER		EMPLOYMENT STATUS (circle) Full-Time Retired Part-Time Not Employed	PATIENT STUDENT STATUS (circle) If 19 Years or Older:	Full-Time Part-Time Not a Student
NOTE: DATE OF BIRTH REQUIRED IN ALL SECTIONS	EMERGENCY CONTACT NAME & PHONE (& RELATIONSHIP)				

RESPONSIBLE PARTY IF PATIENT < 18 YEARS OF AGE

RESPONSIBLE PARTY NAME (Last, First, MI)			SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO RESPONSIBLE PARTY Self Spouse Child Other: ___________________
RESPONSIBLE PARTY ADDRESS (Street, Apt. #)				SOCIAL SECURITY NUMBER	TELEPHONE (Work)
CITY	STATE	ZIP	TELEPHONE (Home)		TELEPHONE (Emergency)

PRIMARY INSURANCE

PRIMARY POLICY HOLDER NAME			SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED PARTY Self Spouse Child Other: ___________________
PRIMARY INSURANCE CARRIER	TELEPHONE	GROUP NUMBER			POLICY ID NUMBER

SECONDARY INSURANCE

SECONDARY INSURANCE POLICY HOLDER NAME			SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED PARTY Self Spouse Child Other: ___________________
SECONDARY INSURANCE CARRIER	TELEPHONE	GROUP NUMBER			POLICY ID NUMBER

Does your primary or secondary insurance require a referral to see a specialist (circle)? Primary YES / NO Secondary YES / NO

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize Lisa Barisciano, MD to render needed treatment to the above named patient.
2. I authorize Lisa Barisciano, MD to release medical or other information, required in the course of examination or treatment, to process patient's claims.
3. I authorize my insurance to be paid directly to the treating physician. I understand that I am responsible for charges not covered by my insurance.
4. I understand that I am responsible for all charges incurred through Lisa Barisciano, MD. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

PATIENT / LEGAL SIGNATURE ______________________ DATE ____________