

Frisco Allergy & Asthma Center

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PATIENT'S INTAKE FORM

Today's Date: _____

Patient name: _____ Gender: M F DOB/age: _____
Emergency Contact: _____ Phone: _____
Primary Physician: _____ Phone: _____
Preferred Pharmacy: _____ Phone: _____
How did you hear about us? Doctor referral Ins. Co. Internet Other Patient Other _____

I. MAIN CONCERN FOR EVALUATION TODAY: _____

Previous allergy testing: No, Yes, year _____ by Dr. _____ located _____
Previous allergy shots: No, Yes, from _____ to _____
Do you have Asthma? No, Not certain, Yes, if so, last lung function test was performed in year of _____

II. REVIEW OF SYSTEMS: (please mark any or all that apply)

General: growth concerns; weight loss; weight gain; fevers; night sweats; Other _____
Head: headaches; dizziness; seizures; fainting spells; sinus pain; Other _____
Eyes: redness; itching / irritation; dry eyes; eyelid swelling; conjunctivitis; Other _____
Ears / Nose / Throat: decreased hearing; sneezing; nasal drainage; nasal congestion;
 itching; sinusitis; nosebleeds; sore throat; snoring; mouth sores; Other _____
Neck: swollen glands; thyroid problems; masses; Other _____
Heart: chest pain; high blood pressure; irregular heartbeats; Raynaud's; Other _____
Lungs: shortness of breath; chest tightness; chronic cough; recurrent pneumonia; Other _____
GI: heartburn / GERD; lactose intolerance; diarrhea; vomiting; abdominal pain; Other _____
Endocrine: diabetes; heat / cold intolerance; heavy / irregular menstrual periods; Other _____
Skeletal: joint pain; muscle aches; weakness; Other _____
Skin: itching; hives; rash; eczema; Other _____
Psychiatric: depression; anxiety; mood swings; Other _____

III. PAST MEDICAL HISTORY:

Eczema No, Yes
Asthma No, Yes
Sinus infection No, Yes
Hives No, Yes
Recurrent ear infection No, Yes
Other recurrent infections No, Yes

Please list other current and former Medical Problems: _____

IV. PAST SURGICAL HISTORY:

Sinus surgery No, Yes, year _____
Ear tubes No, Yes, year _____
Tonsillectomy No, Yes, year _____
Adenoidectomy No, Yes, year _____
Other surgeries _____

Below for Office Use Only

Appointment time: _____ Arrival time: _____ Check-in time: _____
Weight: _____ Height: _____ Temperature _____
Blood pressure: _____ / _____ Heart rate: _____ Resp rate _____
PFT: No, Yes PF: _____ / _____ Bronchodilation @ _____

