# Michael Wein M.D.

Family Allergy Asthma Immunology

**PATIENT NAME:** _____ **DOB**: _____

**Briefly, the main reason for my visit is:** _____

Tell us more about the problem _____

_____

When did it start: _____

How frequent is it: _____

How has it progressed: _____

What makes it worse: _____

What makes it better: _____

Which doctors evaluated it: _____

Which meds have you tried: _____

What treatments tried: _____

What lab tests have you had: _____

What X-rays have you had: _____

**ANYTHING ELSE YOU WANT US TO KNOW:** _____

**How did you hear about our office? Google Physician Referral Friend Other:** _____

**Has any member of your family been treated by us before? Name:** _____

**PLEASE CIRCLE THE CORRECT ANSWERS SO WE CAN LEARN MORE ABOUT YOU:**

Drinking: ☐ DAILY ☐ WEEKLY ☐ RARELY ☐ NEVER

Smoking: ☐ NEVER ☐ CURRENT ☐ FORMER What years did you smoke? _____

Have you ever had allergy testing? ☐ YES ☐ NO Or had allergy injections? ☐ YES ☐ NO

Height: _____in. Weight: _____lbs. Pets: Dog Cat Other: _____

Current school or occupation (If retired, previous occupation): _____

What are your hobbies, how do you spend your time: _____

Years you have lived in Florida_____Where outside of Florida have you lived _____

Live Alone YES NO I live with _____

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**PATIENT NAME:**_____ **DOB**: _____

Name of Primary Care Doctor: _____

Medication Allergies: _____

Food Allergies: _____

Local Pharmacy (Name **and** Address): _____

Mail Away Pharmacy:_____ Account Number: _____

**OTHER MEDICAL HISTORY (Check and comment below)**

☐ Anxiety ☐ Asthma ☐ Eczema ☐ Blood Pressure ☐ Diabetes ☐ Glaucoma ☐ Thyroid

☐ Heart Disease ☐ Hearing Loss ☐ Depression ☐ Sleep Apnea ☐ Cancer

PLEASE LIST ANY OTHERS

_____

_____

_____

**VACCINATION HISTORY**

Pneumonia Vaccine:_____ Date: _____

**PREVIOUS SURGERY** – Reason/dates Please include: Ear Tubes; Nasal/Sinus; Tonsils/Adenoids

_____ _____

_____ _____

_____ _____

**HOSPITAL OR EMERGENCY ROOM VISITS** – **Reason and Dates**

_____ _____

_____ _____

_____ _____

**FAMILY HISTORY (Please Check)**: FATHER: ☐ Alive ☐ Deceased MOTHER: ☐ Alive ☐ Deceased

FATHER: ☐ Asthma ☐ Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Eczema ☐ Cancer (What kind_____)

MOTHER: ☐ Asthma ☐ Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Eczema ☐ Cancer (What kind_____)

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**PATIENT NAME:**_____ **DOB**: _____

**REVIEW OF SYSTEMS – Circle if you have had in the past month**

GENL: ☐ Fever ☐ Weight Loss ☐ Fatigue

EYE: ☐ Itchy Eyes ☐ Blurred Vision

ENT: ☐ Hoarseness ☐ Loss of Smell ☐ Snoring

CARDIAC: ☐ Chest Pain ☐ Palpitations

GASTRO: ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Diarrhea

URINARY: ☐ Difficulty Urinating ☐ Painful Urination

SKELETAL: ☐ Joint pain ☐ Joint swelling

SKIN: ☐ Eczema ☐ Hives ☐ Itching ☐ Sores in Mouth ☐ Rash

NEURO: ☐ Headaches ☐ Migraine ☐ Numbness

BLOOD: ☐ Nose Bleed ☐ Swollen Glands

IMMUNE: ☐ Frequent Infections ☐ Node Swelling

LUNG: ☐ Cough ☐ Shortness of Breath ☐ Wheezing

PSYCH ☐ Depression ☐ Anxiety

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**PATIENT NAME:**_____**DOB**: _____

## Current Medications List

| Name of Medication | Strength | Frequency | Condition | Physician |
|---|---|---|---|---|
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Please remember to include all: ASTHMA INHALERS, NOSE SPRAYS, TOPICAL CREAMS

Current physicians and specialty 1_____2_____3_____

4_____5_____6_____7_____

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**Additional Questions for Patient's 17 Years of Age or Younger:**

☐ ☐ ☐ ☐ ☐ ☐
Birth was: premature, full term, induced, spontaneous, vaginal, cesarean

☐ ☐
Feeding at birth was: breast fed or bottle fed; if bottle fed, what formula: _____

☐ ☐
Immunizations: up-to-date or delayed

☐ ☐
Growth and development: normal or delayed; if delayed, please explain: _____

_____

☐ ☐
Family history of immune deficiency: yes or no

☐ ☐
Siblings: yes or no

☐ ☐
Asthma: yes or no

☐ ☐
Breathing problems: yes or no

☐ ☐ ☐ ☐
Skin problems: hives, rash, eczema, none

☐ ☐
Smoking household: yes or no

☐ ☐
Hospitalizations: yes or no

☐ ☐
Daycare: yes or no

☐ ☐
Attends school: yes or no; if yes, what school: _____

Current diet includes: _____

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## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

3375 20th Street, Suite 140, Vero Beach, FL 32960 ~ Phone 772.299.7299 ~Fax 772.563.9191
320-322 NW Bethany Drive, Port Saint Lucie, FL 34986 ~Phone 772.621.9992 ~Fax 772.563.9191

**Patient Name**: _____

**Date of Birth**: _____ **Cell Phone**: _____

**Home Address**: _____

_____

**Specific Information to be Disclosed/Brief Description of PHI Disclosed**: (check all that apply)

____Lab test results, specify: _____ ____Radiology test results, specify: _____

_____ _____

____Entire Medical Record ____Other, specify: _____

____IT: Injection log, vial contents, skin test results, _____

most recent office notes _____

**Dates of Service requested**: _____

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Recipient: Name of the person(s) to whom MICHAEL WEIN, MD may obtain my health information:

_____

_____

Term: This Authorization will remain in effect:

____From the date of this Authorization until_____.

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_____ _____

**Signature of Patient** Date

*If the patient is a minor or otherwise unable to sign this authorization, obtain the following signature:*

_____

**Signature of Personal Representative**

_____ _____

Description of Authority (guardian, healthcare proxy etc.) Date