Meher S. Khan, MD, Allergy, Asthma & Immunology
146 Montgomery Avenue, Suite 200, Bala Cynwyd, PA 19004
Phone: (610) 668-0836 Fax: (610) 668-7922 Website: www.allergymomMD.com

New Patient Form

Patient Name:_____

Address:_____

_____

Email:_____

Home Phone:_____ Cell Phone:_____

Preferred Method of Contact (circle one): Email Home Phone Cell Phone

Date of Birth:_____ / _____ / _____

Gender: _____

Ethnicity: _____

Insurance Carrier: _____ Member Number:_____

Please Attach copy of front and back of Insurance Card and Driver's License!

Referral Needed? Y _____ N _____ Dr. Khan's NPI # 1871555458 (for referrals)

*__Referred By__? Family___ Physician___ Friend___ Other___Name:_____

Have you seen an Allergy and Asthma Specialist Previously? Y____N____Name:_____

Previous Allergy Shots (Immunotherapy)?_____

Primary Care Doctor:

Name:_____

Address:_____

Phone:_____Fax:_____

Pharmacy:

Name:_____

Address:_____Zip Code:_____

Phone:_____ Fax:_____

Reason for your visit today?

_____

_____

_____

Allergy Symptoms: (please circle)

Ear/Eyes/Nose/Throat:	Seasonal	Year Round	Food Related		
Asthma/Bronchitis:	Seasonal	Year Round	Food Related		
Skin:	Eczema	Hives	Acne	Swelling	Other
Heartburn/Gastritis:	Seasonal	Year Round	Food Related	Stress Related	
Headache/Sinus Congestion:	Seasonal	Year Round	Food Related		
Frequent Childhood Illnesses:	Ear Infections	Mucus	Bronchitis	Croup	Headaches

Current Medications:

Please include all Vitamins, Herbal Supplements, Birth Control Pills, Allergy/Asthma, Nebulizer, etc.
Name/Dose/Frequency

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Use back of sheet if more space is needed.

Allergic History:

Do you have allergies to any MEDICATION or LATEX? (Y/N)_____
If yes, please explain:_____
_____

Do you have FOOD ALLERGIES? List foods and reactions #, symptoms, duration, treatment, response, ER visit, hospitalization, in DETAIL:

1.

2.

3.

Use additional sheets if necessary.

Do you have INSECT or MOSQUITO allergies? (Y/N)_____
If yes, please explain:_____
_____

Environmental History:

Please describe your primary residence (please circle):

House Apartment Rowhouse Beach house Dorm Other_____

Approximate age of building? Greater than 50 Less than 50 Other_____

How long have you lived there?_____

Please circle all that apply -

Basement:	Carpet		Moldy Smell	Water Leakage	Discoloration
Heating System:	Oil	Gas	Electric	Radiator	Other_____
Air Conditioning:	Central		Units	None	Other_____
Bedroom Floors:	Hardwood		Carpet	Tile	Other_____
Other Rooms' Floors:	Hardwood		Carpet	Tile	Other_____

Plastic Casing on: Mattress Pillow Box Springs Other_____

Feathers or Down: Bedding Pillow Upholstery Jackets

Do you have: Room Purifier Air Filter Cool Mist Vaporizer Humidifier

Do you have: Pets (dogs, cats, etc.), how long?_____
_____

Do you have: Any secondary residences (dorm, beach house, etc. :_____
_____

Work/Hobbies:
Occupation:_____ Employer:_____
Hobbies: _____

School:_____Grade:_____

Please describe your **work/school environment**:_____
_____
_____

Do your symptoms at **work/schoo**l (please circle): Increase Decrease Same

Is there (please circle): Smoke Mold Dust Pets Other_____

Smoking History:
Do you, or did you ever, smoke? (Y/N)_____ If yes, packs per day:_____
For how many years?_____ If you are a former smoker, when did you quit?_____
Are you exposed to passive (second-hand) smoke? (Y/N)_____If yes, how often?_____
E-cigarette? (Y/N) _____ Chewing Tobacco? (Y/N)_____

Social History:
How much **alcohol** do you drink and how often?_____

Have you used **drugs**? (Y/N)_____ Explain:_____
Do you **exercise** regularly? (Y/N)_____ How often?_____
What types of exercise?_____
How is your **nutrition and lifestyle** balance?_____
_____
Do you frequently feel (please circle):
Stress Anxiety Panic Shortness of Breath
Stress Level: 0 to 10 _____ List Causes or triggers:
_____
_____

_____

Patient History:
Please list all chronic medical conditions:

_____
_____
_____

Are you pregnant? Yes No Not applicable
Number of Children:_____ Ages:_____

Family History: (please list all chronic illnesses, diseases, cause of death, etc.)
Father:_____
Mother:_____
Grandparents:
Maternal Grandmother:_____
Maternal Grandfather:_____
Paternal Grandmother:_____
Paternal Grandfather:_____
Brother(s):_____
Sister(s):_____
Children:_____
Extended family members:_____
Surgical History:

_____
_____
_____

Vitals:
Height:_____ Weight:_____ Blood Pressure:_____ / _____
Pulse:_____/min. Peak Flow:_____L/min

PERMISSION for us to communicate with you, and/or leave messages with lab results by:
Email (non-secure, password-protected)_____**Phone/Cell/Text**_____
Patient Portal (secure, password-protected)_____**Other**_____

Name: _____**Signature:**_____**Date:**_____
Please return this completed questionnaire along with previous medical records and laboratory tests and reports via email, fax or mail 24-48 hours prior to your appointment.