Meher S. Khan, MD, Allergy, Asthma & Immunology
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Bryn Mawr, PA 19010
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HIPAA and TERMS OF SERVICE

New Patient Form

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:_____

Primary Care Doctor:
Name:_____
Address:_____
Phone:_____Fax:_____

Pharmacy:
Name:_____
Address:_____ZipCode:_____
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._____

Allergic History:

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

_____

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

_____

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 years. Less than 50 years

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 Other

Please describe any pets (dogs, cats, etc.), Breed, how
longhave you had them?

_____

Please describe any secondary residences_____

Work/School History: Occupation:_____

Employer:_____

School:_____Grade:_____

Please describe your work/school
environment:_____

_____

Do your symptoms at work/school (please circle): Increase Decrease Same

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

Social 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 (secondhand) smoke? (Y/N)_____If yes, how often?_____ Ecigarette? (Y/N) _____ Chewing Tobacco? (Y/N)_____

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?_____ ____ Other hobbies or sports?_____ __

How is your nutrition and lifestyle?
_____

Do you frequently feel (please circle):
Stress Anxiety Panic Shortness of Breath Stress Level: 0 to 10 _____
List Causes or Triggers of Stress :
_____
_____

Patient History: Please list all chronic medical conditions:
_____
_____

_____

Please list all surgical procedures with dates:

_____

_____

_____

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:

MaternalGrandmother:_____

MaternalGrandfather:_____

PaternalGrandmother:_____

PaternalGrandfather:_____

Brother(s):_____

Sister(s):_____

Children:_____

Extended family:

_____

Vitals: Height:_____Weight:_____

BloodPressure:_____ / _____ Pulse:_____/min.

Peak Flow:_____L/min

PERMISSION for us to communicate with you, and/or leave messages with lab results by:

Email (nonsecure, passwordprotected)_____

Phone/Cell/Text_____

Patient Portal (secure, passwordprotected) _____

Other_____

HIPAA and TERMS OF SERVICE: https://allergymommd.com/terms-of-service

By signing below I acknowledge that I have read and consent to HIPAA and Terms of Service per link above and that all information entered is accurate.

Name: _____

Signature:_____ Date: _____

Please return this completed questionnaire along with previous medical records and laboratory tests and reports via email, fax or mail to arrive at least 24 to 48 hours prior to your appointment.

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