



New Patient Consultation

WELCOME TO APEX!

Name _____ Date _____

Date of Birth _____ Age _____ Name You Go By _____

Pharmacy Name / Location / Phone (If known) _____

Primary Care Provider _____ Referring Provider _____

Are there any other providers currently treating you for your problem? If yes, please list. _____

Have you had any labs or imaging done in the last 6 months? Yes No

Please sign and return a records release for each of the above providers listed. This is so we can ensure that we have any notes, labs or imaging results that will be needed for your visit.

Describe the reason for your visit _____

List All Current Medicines and Dosages

List Surgeries

Allergy / Sinus Testing

Have you been tested by an allergist in the past 5 years? No Yes, by Dr. _____

Results of allergy tests: No Allergy Positive to: _____

Have you been evaluated by an ENT in the past 5 years? No Yes, by Dr. _____

Have you had a sinus CT in the past 5 years? Yes No

Have you had sinus or nasal surgery performed by an ENT in the past 5 years? Yes No

Have you ever had blood work specifically evaluating your immune system? Yes No

Do any foods cause you to have hives, itching, swelling or anaphylaxis? No Yes _____

Have you ever had an insect sting that resulted in a severe allergic reaction? No Yes

Social History

Marital Status: Dependent Child _____ Single _____ Married _____ Divorced _____ Widowed _____

Student _____ School / Grade _____

Current or Most Recent Occupation _____

Birthplace (City / State): _____

Indoor Pets: Cats _____ Dogs _____ Other Pet Exposures _____

Family History

Do you have any parents or siblings with the following?

Hay Fever / Nasal Allergies: No Yes, list _____

Asthma: No Yes, list _____

Other pertinent family history: _____

Drug Allergies

List any drugs causing serious reactions (Other than nausea / Vomiting):

Do you have any relatives or friends that are patients here?

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