

Acknowledgement of Receipt of Notice of Privacy Practices

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Olga Camacho – Privacy Officer - 949-495-2500**

I acknowledge that I have received a copy of this medical practice's Notice of Privacy. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy at each appointment and by email at (your email address) at:

_____@_____

Print Name: _____ Date: _____

Signed: _____ Phone: _____

If not signed by the patient, please indicate:

Name of Patient: _____

Relationship: _____

Date _____

Patient Information

Patient Name _____

Age _____

M / F

Primary Physician _____

Primary Language _____

List Current Medications/Supplements:

Medicine Allergies/Reactions: _____

Diet/Food Avoidances: _____

List Non-Asthma/Allergy Health Problems:

Hospitalizations:

Surgeries:

Have You Had?

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Blood Infection	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> HIV
<input type="checkbox"/> Gastrointestinal Infection	<input type="checkbox"/> Other Infection	_____	

Female Patients: Are You Pregnant _____ On Birth Control _____ Hormone Replacement _____

Children: Are Vaccines Up to Date _____ Reactions: _____

List Family Health History:

Mother:

Father:

Bro/Sister:

Extended Fam:

Allergy:

Asthma:

Eczema:

Infections:

Other:

OVER to Side 2

Do You Smoke? _____ Years _____ Pack/Day _____ Quit _____ How Long Ago _____

Is There Tobacco Exposure at Home _____ Car _____

Is There Pet Exposure? _____ At Home/Other: _____

What Animals _____

Where are they Allowed? Indoor/Outdoor/Bedroom _____

Is There Exposure to: Ill Contacts/Siblings/School/Daycare _____

Where do you live? City _____ Home/Apt/Condo _____

Are you Near? Park/Open Space/Freeway(1000 yrds) _____

Do you have? Windows Open/AC/Fans/Air Filters/Carpet/Curtains _____

Are There Unusual Home Exposures? _____

Remodeling/WaterDamage/Chemicals/Paint/Glue/Solvents/Candles/Incense/Rodents _____

What is your Current Job? _____

Are there Unusual Work Exposures Now or Previously? _____

Hobbies _____

Sports/Exercise _____

Other Activities/Exposures _____

Review of Systems: please circle all symptoms that occur

Eyes: itch, water, swelling, vision difficulty, discharge, dark circles

Ears: impaired hearing, congestion, popping, pain, itch

Nose: sneeze, itch, congestion, discharge, clear/colored, postnasal drip, bleeding, decreased smell

Sinus: pressure, headache, bad breath, throat clearing, tooth pain

Throat: itch, tight, pain, mucous, hoarse

Chest: cough, pain, wheeze, tight, short of breath, exercise difficulty, night cough/waking, sputum

General: weight loss, poor energy, poor sleep, snoring, fever, hair loss

Neuro/Psych: headache, dizziness, fainting, numbness, seizures, depression, anxiety, stress

Endo: heat or cold intolerance, increased urination, thyroid disease, diabetes

Resp: bronchitis, pneumonia, emphysema, TB exposure

Cardio: high blood pressure, unusual heart beats, chest pain, exercise intolerance, edema

Gastro: heartburn, nausea, vomit, gas/bloating, diarrhea, constipation, abdominal pain

Musculosk: joint pain, stiffness, swelling, muscle aches

Heme: anemia, easy bruising, unusual bleeding, pale, swollen lymph nodes

Urinary: infections, pain, blood, frequency, prostate hypertrophy

Immune: recurrent infections/sinus/otitis/pneumonia

Skin: birthmark, rash, pruritis

Genital/Gynecol: discharge, STDs, irregular menses, discharge, dysuria