California Allergy & Asthma Medical Group, Inc.

Research Division

REGISTRATION FORM

(Please Print)

Today's date:	(Please give your driver's license to the receptionist.)

PATIENT INFORMATION

Patient's last name:	First:	Middle:

Birth date: / /	Age:	Sex: ❑ M ❑ F	Referred to clinic by (please check one box): ❑ Family/Friend ❑ Other	Cell phone no.: ( ) Home phone no.: ( )

Street address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Street address:	City:	State:	ZIP Code:

MEDICAL HISTORY

Social History

History of smoking?	❑ Previous Smoker ❑ Current Smoker ❑ N/A

Start Date: / /	Stop Date: / /	How many packs per day?

History of drug and/or alcohol abuse? ❑ Yes ❑ No	If yes, please elaborate below.

Allergy History

Do you have environmental allergies?	If yes, how many years?
Have you ever been skin tested?	If yes, approximate date?
Which seasons do you suffer?	❑ Spring ❑ Summer ❑ Winter ❑ Fall
Do you have any drug allergies?	If yes, please specify?

Current Medication

Please include all prescription and over-the-counter medications you have used over the **past 6 months**. This includes vitamins, herbs, antacids, eye drops, etc

Name of Drug	Dose per day	Start Date:	Stop Date or check if ongoing		Reason for use
		/ /	/ /	☐	
		/ /	/ /	☐	
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Medical History

		Description of Problem	Onset Date	Resolved Date or check if ongoing	
Head, eyes, ears, nose, throat (e.g. allergies)	Yes / No		/ /	/ /	☐
Cardiovascular	Yes / No		/ /	/ /	☐
Respiratory (e.g. asthma)	Yes / No		/ /	/ /	☐
Digestive (e.g. stomach)	Yes / No		/ /	/ /	☐
Liver	Yes / No		/ /	/ /	☐
Endocrine (e.g. diabetes)	Yes / No		/ /	/ /	☐
Kidney	Yes / No		/ /	/ /	☐
Reproductive	Yes / No		/ /	/ /	☐
Muscles, Bones, Joints	Yes / No		/ /	/ /	☐
Neurologic (e.g. headaches, dizziness)	Yes / No		/ /	/ /	☐
Psychiatric	Yes / No		/ /	/ /	☐
Skin	Yes / No		/ /	/ /	☐
Blood (e.g. anemia)	Yes / No		/ /	/ /	☐
Major surgeries (please list on the back of the this page)	Yes / No		/ /	/ /	☐
Other	Yes / No		/ /	/ /	☐

Patient/Guardian signature:

Date: / /