Meher S. Khan, MD, Allergy, Asthma & Immunology
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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:________________

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? (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 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

Please describe any pets (dogs, cats, etc.), how long?____
____

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 (second-hand) smoke? (Y/N)_______If yes, how often?_______________
E-cigarette? (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 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:

____
____
____

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:
Maternal Grandmother:_______________________________________
Maternal Grandfather:_______________________________________
Paternal Grandmother:_______________________________________
Paternal Grandfather:_______________________________________
Brother(s):____
Sister(s):____
Children:____
Extended family members:_____________________________________

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.

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