INITIAL VISIT QUESTIONNAIRE

Please answer all pertinent questions (parents should answer for children).
This is a part of your medical history and is therefore confidential.

Name: _____ Birthdate: _____ Birthplace: _____

Occupation: _____ Previous Occupation: _____

Date last physical exam: _____ Physician's name: _____

Briefly describe your symptoms and why you are here (doctor will question you for details):

_____

Frequency of symptoms: _____ Duration of symptoms: _____ Initial onset: _____

Factors which aggravate these symptoms: _____

Symptoms worse during (circle): Jan., Feb., Mar., April, May, June, July, Aug., Sept., Oct., Nov., Dec., all yr., variable

Number of days missed from school or work because of symptoms (if any) _____

Past Illnesses & Dates	All Medications Including Over The Counter
_____	_____
_____	_____
_____	_____

Ever had any adverse reactions to medications (if so which ones) _____

Ever had any adverse reactions to foods(if so which ones) _____

ENVIRONMENT- (circle if appropriate)

Home: city rural house apartment condo Heat: gas oil electric
forced hot air hot water baseboard other_____humidifier (if yes-type)_____
number of rooms _____ stuffed furniture

Bedroom: shared single pillow: feather foam rubber synthetic
mattress: polyester cotton foam rubber other_____
is it covered with an allergy proof cover? yes / no
carpet/area rugs? none wall to wall wool synthetic
curtains or drapes? yes / no blankets: wool feather down synthetic

Crawlspace / Bilevel / Basement: yes / no if yes, is it: damp/musty / dry / finished

Pets: dog cat bird other_____none are they outside? yes / no / both

Do you have contact with insecticides? _____ number of houseplants _____

General information:

Do you smoke? yes / no cigarettes pipe cigar How many per day? _____How long?_____

Recent changes in weight? _____ persistent cough _____ post-nasal drip _____

Do you take vitamins? _____ Do you take herbals? _____

RECORDS RELEASE

I hereby authorize Robert P. Rabinowitz, D.O., P.A. to release any records including informatio regarding diagnosis/treatment to my insurance co.,any physician. or any other person(s) involved with m health.

I authorize use of this signature for release of payment from my insurance company to Robert F Rabinowitz, D.O., P.A. for services rendered.

Signature _____

Date _____