# Continued: PBIM Intake Form:

Pompano Beach Internal Medicine

PLEASE ANSWER AS THOROUGHLY AS POSSIBLE

Full Patient Name :_____
Insurance:_____ Phone:_____

1. Do you suffer from any of the following symptoms? (Check all that apply)

| Nasal | ☐ | Sinus | ☐ | Eyes | ☐ |
|---|---|---|---|---|---|
| Runny or Stuffy Nose | ☐ | Headaches | ☐ | Red | ☐ |
| Sneezing | ☐ | Sore Throat | ☐ | Itching | ☐ |
| Itchy Nose | ☐ | Post Nasal Drainage | ☐ | Watery | ☐ |
| Nose Bleeds | ☐ | Hoarseness | ☐ | Dark Circles | ☐ |
| Mouth Breathing/Snoring | ☐ | Throat Clearing | ☐ | Puffiness | ☐ |
| Sniffling | ☐ | Itchy Throat | ☐ | | |

| Chest | ☐ | Ears | ☐ | Skin | ☐ |
|---|---|---|---|---|---|
| Wheezing | ☐ | Full | ☐ | Rash | ☐ |
| Coughing | ☐ | Painful | ☐ | Hives | ☐ |
| Tightness | ☐ | Ringing | ☐ | Eczema | ☐ |
| Shortness of Breath | ☐ | Hearing Loss | ☐ | Swelling | ☐ |
| Chronic Bronchitis | ☐ | Itching | ☐ | Itching | ☐ |

2. Do you have family members with allergies? ☐YES ☐NO
   a. If yes, relationship: _____

3. Have you ever been diagnosed with asthma? Details : _____

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τ Have you ever undergone Allergy testing? ☐YES ☐NO
   a. If yes, Date begun_____ Date ended_____

υ HAVE YOU RECEIVED Allergy Shots? ☐YES ☐NO
   a. If yes, Frequency? _____
   Date begun: _____ Date ended_____
   WHAT SPECIFIC ALLERGIES WERE YOU TREATED OR RECEIVED TREATMENT FOR:
:_____

6. Adverse reactions to allergy shots? (PLEASE Describe)

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7. Do you take Over The Counter medicines for allergies? ☐YES ☐NO