NEW PATIENT FORM
MURFREESBORO MEDICAL CLINIC
Dr. John Kolisnyk, D.O., Allergy & Immunology
(COMPLETE ALL INFORMATION)

Date:_____ MRN:_____ EMAIL:_____
Name:_____ DOB:_____
Primary Provider (Doctor) _____ Referring Provider (if known)_____
Pharmacy_____Location_____

OFFICE USE ONLY: _____*Height* _____*Weight* _____*BMI*_____*B/P* _____*HR* _____*Temp.*

(COMPETE ALL INFORMATION BELOW)

Chief Complaint(s):_____
History of Present Illness/Review of Systems: **Please circle any that apply to today's visit**
HEENT: itchy eyes red eyes watery eyes runny nose congestion sore throat throat itching ear discomfort ringing in ears hearing difficulties ear popping ear pressure poor smell poor taste
CV: chest tightness palpitations
RESP.: shortness of breath wheezing wheezy cough dry cough productive cough snoring mouth-breathing
GI: nausea vomiting diarrhea difficulty swallowing painful swallowing
MS: joint pains muscle pains muscle cramps
NEURO: general weakness tremors headaches dizziness lightheadedness
SKIN: rashes itching hives swelling flushing flaking eczema weeping

Past Medical History: Please circle any that apply

Acid Reflux	Diabetes	High Blood Pressure	Nasal Polyps
Asthma	Ear Infection (otitis)	Hives (Urticaria)	Nicotine Dependence
Bee/Fire Ant Allergy	Eczema	Hypo/Hyperthyroidism	Pneumonia
Cancer	Excessive Bleeding	Immune Deficiency	Sinusitis
Contact Skin Allergy	Food Allergies (specify below)	Kidney Disease	Other:_____
COPD	Heart Disease	Liver Disease	

Past Surgical History: Please circle any that apply.
Adenoidectomy Ear Tubes Septoplasty Sinus Surgery Tonsillectomy Turbinoplasty
Other: (Please list)_____

Social History: Current or Prior Tobacco Use: Y / N Type:_____ Average Daily use X years:_____
Secondhand Smoke Exposure: Y / N (at Work or Home or Both?) Occupation: _____

Family History: Please circle any that apply.

Allergy/Sinus Diseases	Cancer	Eczema	High Blood Pressure	Nasal Polyps
Asthma/COPD	Cystic Fibrosis	Hay Fever	Hives	
Autoimmune Diseases	Diabetes	Heart Disease	Immune deficiency	Other:_____

Environmental History:
Do you live in a: house ____ apartment____ mobile home____ Home Area: Urban_____ Suburban____ Country____
How old is your home? _____ Is there a mold or mildew problem in the home?_____
Wall to wall carpet? Y / N How old is the carpet?_____
How old are your pillows?_____ How old is your mattress?_____
Type of heating system: gas____ electric____ space heater____ wood burning:_____
Pets in the home? Y / N Type/Number? _____ Vacuum Cleaner Type & Age? _____
Adverse Drug Reactions: _____
Current Medications and Supplements:
_____
_____

Suspected Factors Contributing to Symptoms: Please circle any that apply
Mowed grass Perfumes Wind Pollen Molds Soaps Humidity/Temperature/Climate Changes
Detergents Chemicals/Fumes Dust Viruses/Infection Alcoholic Beverages
Cats Dogs Smoke Foods Running/Exercise Other:_____