Allergy & Asthma Care

Patient's Name: _____
Address: _____
City: _____State: ____ Zip: _____
Date of Birth: _____/_____/_____
☐ Male ☐ Female
Race: _____ Ethnicity: _____
Language 1st: _____ 2nd: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Occupation: _____
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____

Family Doctor/Pediatrician:_____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____

Pharmacy: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Who is the subscriber on the patient's insurance?
☐ Self ☐ Spouse ☐ Father ☐ Mother

Spouse's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____/_____/_____
☐ Male ☐ Female
Occupation: _____
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____

<u>If the patient is a minor (under 18) please complete:</u>
Father's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Date of Birth: _____/_____/_____
Occupation: _____
Employer: _____

Mother's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone:
Work Phone: _____
Cell Phone: _____
Date of Birth: _____/_____/_____
Occupation: _____
Employer: _____

How did you hear about us? _____
If referred, who referred you? _____

PATIENTS UNDER AGE 18 MUST BE ACCOMPANIED BY A PARENT OR DESIGNATED ADULT IN ORDER TO BE SEEN.

In order to provide a high quality initial assessment, we schedule a lengthy first appointment for our new patients. If you are unable to keep this scheduled appointment, we require a 24 hour cancellation notice. If a cancellation notice is not given 24 hours in advance, a $40.00 administrative fee will be charged.

The patient is responsible for:

- **Co-pays, deductibles and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled.**
- **All outstanding balances that are over 30 days old, will incur a monthly statement processing fee, in addition to the initial balance.**
- **We accept cash, check and credit card. (Visa, MasterCard and Discover)**

OFFICE USE ONLY:

_____

All information reviewed by:

_____

<u>PLEASE DO NOT WEAR FRAGRANCES</u>

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Please describe in your own words the reason for your visit: _____
_____
_____
_____

Please list the name and dates of all medications you have tried for this: _____
_____
_____
_____

EVALUATION FOR ASTHMA:

At what age were you diagnosed with asthma? _____
Have you had any hospitalizations or ER visits for asthma? ☐ Yes ☐ No
If yes, list approximate dates: _____
Have you been treated with steroid pills for asthma? ☐ Yes ☐ No
If yes, how often? _____ When was the last time?_____
Have you been prescribed any of the following inhalers? ☐ Advair ☐ Symbicort ☐ Dulera ☐ Flovent
☐ Asmanex ☐ QVAR ☐ Pulmicort ☐ Alvesco ☐ Aerobid ☐ Azmacort
What symptoms of asthma do you experience? ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness
How many days per week do you experience these symptoms? _____
How many days per week do you use a rescue inhaler? _____
How many nights per month does your asthma hinder your ability to sleep? _____
What triggers your asthma? ☐ Exercise ☐ Laughter ☐ Crying ☐ Cold ☐ Heat ☐ Respiratory infections
☐ Change of seasons ☐ Pollens ☐ Animals ☐ Dust ☐ Mold ☐ Strong smells (tobacco, perfumes, detergents, etc.)

EVALUATION FOR HAY FEVER:

Check the following symptoms that affect you: ☐ Sneezing ☐ Runny nose ☐ Stuffy nose ☐ Post nasal drip
☐ Itchy eyes ☐ Itchy ears ☐ Itchy nose ☐ Itchy throat ☐ Watery eyes ☐ Swollen eyes ☐ None
When do these symptoms bother you? ☐ All year long ☐ Certain months only (list): _____
What exposures make these symptoms worse? ☐ Indoors ☐ Outdoors ☐ Strong smells (perfumes, cleaning detergents, etc.) ☐ Rainy days ☐ Dry & windy days ☐ Cats ☐ Dogs ☐ Dust ☐ Molds ☐ Feathers/Birds
What medications have you tried? _____
_____

EVALUATION FOR SINUSITIS:

Do you struggle with frequent sinus infections? ☐ Yes ☐ No If yes, how many in a given year? _____
Have you ever had nasal polyps? ☐ Yes ☐ No Have you lost your sense of smell or taste? ☐ Yes ☐ No
Have you ever had sinus surgery? ☐ Yes ☐ No If yes, list dates: _____

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EVALUATION FOR HEADACHES:

Do you struggle with headaches? ☐ Yes ☐ No If yes, check the description of the headaches that apply:
☐ Pulsating pain ☐ Constant pain ☐ Associated with intolerance of loud sounds or bright lights
☐ Worse with physical exertion ☐ Duration > 4hrs ☐ Debilitating ☐ Located only on one side of the head
☐ Located on both sides of the head

EVALUATION FOR HIVES:

When did current bout of hives start? _____ How often are they occurring? _____
How long does each individual hive last? _____ Are the hives intensely itchy? ☐ Yes ☐ No
Do the hives leave dark marks? ☐ Yes ☐ No Have you had any illness before onset of hives? ☐ Yes ☐ No
Do you suspect any food triggers? ☐ Yes ☐ No If yes, what foods? _____
Do you take any ibuprofen or ibuprofen-like medications? ☐ Yes ☐ No If yes, list: _____
Have you noticed hives to be worse with the following? ☐ Heat ☐ Cold ☐ Exercise ☐ Scratching ☐ Stress
☐ Showers ☐ Menses ☐ Alcohol ☐ Pressure on the skin (such as waist band/bra strap areas)
Have you ever had hives before in your lifetime? ☐ Yes ☐ No
Have you had swelling? ☐ Yes ☐ No
Have you noticed any of the following? ☐ Throat closing ☐ Shortness of breath ☐ Change in your voice
☐ Tongue swelling ☐ Sensation of something stuck in your throat

OTHER ALLERGIC HISTORY:

Do you have food allergies? ☐ Yes ☐ No If yes, list each food or meal and the reaction you had to it:
_____
_____
_____

Have you had any problems after bee or wasp stings? ☐ Yes ☐ No If yes, describe the reaction (Do not include reactions to mosquito bites): _____
Do you have any drug allergies? ☐ Yes ☐ No If yes, list each medication and describe the reaction:
_____
_____

Do you have a history of latex allergy? ☐ Yes ☐ No If yes, describe the reaction: _____
_____
_____

Do you have a history of eczema? ☐ Yes ☐ No

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MEDICATIONS:

List all medications you currently take (include all over-the-counter medications, eye drops, nasal sprays, inhalers, birth control pills, digestive aids, vitamins, supplements, aspirins, etc.)

_____
_____
_____

MEDICAL HISTORY:

Please list all chronic medical conditions:

_____
_____
_____
_____
_____
_____
_____
_____

Please list all surgeries and hospitalizations with dates:

_____
_____
_____
_____
_____
_____
_____
_____

FOR CHILDREN UNDER 15: What was the birth weight? _____

Were there any complications before, during or after the delivery? ☐ Yes ☐ No If yes, please explain:

_____
_____
_____
_____

Has growth and development been normal? ☐ Yes ☐ No If no, please explain:

_____
_____
_____

FAMILY HISTORY:

Illness/Complaint	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Asthma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐
Drug Allergy	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐

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ENVIRONMENTAL SURVEY:

What type of heating/cooling system do you have in your home?
☐ Forced air ☐ Radiator ☐ Baseboard heat ☐ Central air ☐ Window units ☐ Wood burning heat ☐ Fans
Does anyone in your household smoke? ☐ Yes ☐ No If yes, where? ☐ Indoors ☐ Outdoors
Are there any obvious mold problems? ☐ Yes ☐ No Do you use humidifiers? ☐ Yes ☐ No
Is there wall to wall carpeting? ☐ Yes ☐ No If yes, which rooms? _____
Do you use feather pillows? ☐ Yes ☐ No Do you have down comforters or down coats? ☐ Yes ☐ No
Do you have any family pets? ☐ Yes ☐ No If yes, please list: _____
Are there any young children in your home? ☐ Yes ☐ No If yes, list ages: _____

SOCIAL HISTORY:

Occupation: _____
How much alcohol do you drink and how often? _____
Do you, or did you ever, smoke? ☐ Yes ☐ No If yes, how many packs per day on average? _____
For how many years? _____ If you no longer smoke, when did you quit? _____
Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise? _____

REVIEW OF SYMPTOMS:

General: ☐Chills ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss ☐ None
Eyes: ☐Dryness ☐ Pain ☐ Redness ☐ Vision changes ☐ None
Ears: ☐Hearing loss (L, R, Both) ☐ Fullness ☐ Ringing ☐ None
Nose: ☐Bloody nose ☐ Discolored discharge ☐ Sense of smell ☐ Sinus pressure ☐ None
Mouth: ☐Dental problems ☐ Sense of taste ☐ Thrush ☐ Oral ulcers ☐ None
Cardiovascular: ☐Chest pain ☐ Palpitations ☐ None
Respiratory: ☐Chest tightness ☐ Cough ☐ Shortness of breath ☐ Wheeze ☐ None
Gastrointestinal: ☐Abdominal pain ☐ Excessive burping ☐ Bloating ☐ Diarrhea ☐ Indigestion ☐Nausea ☐ None
GU Female/Male: **Female:** ☐ Irregular menses ☐ None / **Male:** ☐ Flank Pain ☐ Groin Pain ☐ None
Musculoskeletal: ☐Leg swelling ☐ Muscle aches ☐ Numbness ☐ Joint pain ☐ Tingling ☐Weakness ☐ None
Skin: ☐Rash ☐ Brittle hair ☐ None
Neurological: ☐Headache ☐ Lightheadedness ☐ Loss of consciousness ☐ None
Psychological: ☐Anxiety ☐ Depression ☐ Sleep pattern disturbance ☐ None
Endocrine: ☐Hot flashes ☐Excessive sweating ☐None