REGIONAL
ALLERGY ASTHMA & IMMUNOLOGY CENTER

W. JAN KAZMIER, M.D., Ph.D., FAAAAI • SHAILEE MADHOK, M.D., FACAAI

Phone 423-246-6445 Fax 423-246-8240

2312 KNOB CREEK ROAD, SUITE 206
JOHNSON CITY, TN 37604

2995 FT. HENRY DRIVE, SUITE 100
KINGSPORT, TN 37664

# New Patient Information

NAME:_____

APPOINTMENT:_____

We would like to welcome you to our office. Please take a few minutes to get familiar with some information contained in this letter before you come.

- If you are scheduled for NEW SKIN TESTING appointment, you will need to **discontinue** any prescription antihistamines (such as Zyrtec, Allegra, Claritin, Clarinex, Hydroxizine, Atarax, etc.) "**2** weeks" prior to scheduled appointment and any over-the-counter antihistamines (such as Benadryl or Tavist) "**4** days" prior to scheduled appointment.
- If you are schedule for CONSULT ONLY, you do not need to hold any medications.

1) Please be sure to bring all information pertinent to your office visit (such as insurance cards, referral form from your referring physician if needed, previous allergy medical records and list of ALL current medications).
2) It is also your responsibility to obtain all necessary referrals required by your medical insurance company (John Deere, Select, TN care, any insurance requiring referrals to a specialist).
3) It is your responsibility to call your insurance company and obtain necessary information regarding your co-pays, deductibles, etc. This is to make you aware of ALL costs incurred upon your visit/testing.
4) ALL co-pays are due at time of visit. It is also suggested you make a partial payment toward your deductible if applicable.
5) Please call our office within **48 hours** of your scheduled appointment time in order to cancel or reschedule. This is an extensive visit requiring 2-3 hours of your and our time.

over →

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Dear Patient,

We at Regional Allergy, Asthma & Immunology Center are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To assist you with your healthcare investment, we provide the following payment options:

**PAYMENT OPTIONS:**

1. Cash- Includes money orders and personal checks.

2. Visa / MasterCard / Discover / Debit Cards

3. Easy-Pay Payment Plan – Monthly Payment Option

    - Interest Free Option on balances paid off with in 90 days.(3 monthly payments)
    - Low interest Extended Payment Plan Option.
    - No annual fees or pre-payment penalties.

We are happy to provide you with the above options to allow you to make convenient, low monthly payments. If the Easy Pay Payment Plan is your preferred option, you can begin any necessary treatment immediately and spread the payments out over time. For more information or to set up this option please contact our office prior to your scheduled appointment date. **Any insurance co-pays or deductibles are payable at time of service and are excluded from the Easy Pay Payment Plan.**

Enclosed, you will find patient registration forms and pertinent information related to your appointment with our office. Please fill out all forms completely and return to our office at time of your appointment.

**If your insurance requires a referral from your primary care physician, please bring one with you at the time of your visit, or you may have one faxed to our office at 423-246-8240.**

We look forward to seeing you at your scheduled appointment with, _____ at_____ on _____. We are pleased you have chosen to become a member of our client family.

Sincerely,

Regional Allergy, Asthma & Immunology Center

over →

Patient ID _____

# Regional Allergy, Asthma & Immunology Center, P.C

## NEW PATIENT INFORMATION SHEET

### (All Blanks Must Be Completed – If You Needed Assistance, Please Let Us Know)

Patient Name (Legal Name): _____ Birth Date: _____/_____/_____ Age: _____

Sex: M____F____ Address: _____

ZIP: _____ City/State: _____

SSN# (required) __ __ __- __ __- __ __ __ __ Home Phone#: (_____) _____ Work Phone#: (_____)_____

Cell Phone#: (_____)_____ Email:_____ Married___ Single___ Divorced___ Widowed ___

**Primary Contact Number** (please circle one): Home Work Cell Other: (_____) _____

May we communicate with you by (Check to indicate approval): Text Message ____ Email _____

Patient's Employer _____ Employer's Address _____

How Long Employed _____ If Student, what school _____

Patient Ethnicity: Hispanic or Latino: Yes ___ No ___ Primary Language: English ___ Spanish ___ Other _____

Race: White ___ African ___ Asian ___ Other ___ Preferred Pharmacy: _____

Pharmacy Phone: _____ Clinician patient is seeing today: ___ Dr. Madhok ___Dr. Kazmier

Primary Care Physician _____ Referring Physician _____

**IF PATIENT IS A MINOR OR IF PATIENT IS MARRIED:**

**Mother's/Wife's Name:**_____ Address: _____

City/State/Zip_____ Home Phone #: (_____)_____

Work Phone#: (_____)_____Cell Phone#: (_____)_____ DOB: ___/___/___ Email:_____

Employer (self-employed please provide company name): _____How Long Employed _____

Employer's Address:_____ Married___ Single___ Divorced___ Widowed ___

Is this the financially responsible party? Yes ___ No ___ If so, please provide the SSN# __ __ __-__ __-__ __ __ __ (required)

**Father's/Husband's Name:** _____ Address: _____

City/State/Zip_____ Home Phone #: (_____)_____

Work Phone#: (_____)_____Cell Phone#: (_____)_____ DOB: ___/___/___ Email:_____

Employer (self-employed please provide company name): _____How Long Employed _____

Employer's Address:_____ Married___ Single___ Divorced___ Widowed ___

Is this the financially responsible party? Yes ___ No ___ If so, please provide the SSN# __ __ __-__ __-__ __ __ __ (required)

over →

**PRIMARY INSURANCE INFORMATION: (Insurance information must be verified prior to your visit)**

Subscriber's Name:_____ Birth Date: ___/___/___ SSN #_____-____-_____ (required)

Relationship to Patient: _____ Address: _____

Phone #: (_____)_____ Employer: _____

Employer's Address &Phone:_____

Insurance Company: _____ Insurance ID #: _____

Insurance Address: _____

Account/Group #: _____ Effective Date: _____ Pre-Authorization Required? ___Yes ___No

Co-Pay $_____ Deductible $_____ Remaining Deductible $_____

**SECONDARY INSURANCE INFORMATION:**

Subscriber's Name:_____ Birth Date: ____/____/____ SSN #_____-____-_____ (required)

Relationship to Patient: _____ Address: _____

Phone #: (____)_____ Employer: _____

Employer's Address &Phone:_____

Insurance Address: _____

Insurance Company: _____ Insurance ID #: _____

Account/Group #: _____ Effective Date: _____ Pre-Authorization Required?___Yes ___No

Co-Pay $_____ Deductible $_____ Remaining Deductible $_____

Emergency Contact Name: _____ Relationship _____ Phone (_____)_____

**Assignment of Benefits** – I assign Regional Allergy, Asthma & Immunology Center, P.C. hereinafter referred to as "Regional Allergy Center" providers who perform services for me, all benefits which are or shall become payable from any third party payer. I understand and agree that even though I have assigned my benefits to the providers, I remain financially responsible for the payment of all medical care and treatment provided to me by my physicians, or other health care providers. I also understand that payment for any service provided by Regional Allergy Center that is not covered by insurance is due in full at the time the service is provided. I also agree to continuously keep Regional Allergy Center updated of any and all changes regarding my insurance, address, phone numbers and employment as I understand that this information can financially impact my personal financial responsibility and is necessary for the processing of my medical insurance for each and every service provided by Regional Allergy Center. I understand that it is solely my responsibility to do this and if I do not, I will be personally financially responsible as a result.

SIGNATURE_____ DATE _____

"SIGNATURE ON FILE" will automatically print your name on the claim form, allowing your insurance to pay us directly.

**Records Release** – I hereby authorize the release of any information, including medical and billing information, by Regional Allergy Center to my referring physician and insurance company(s).

SIGNATURE _____ DATE _____

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# Office Guidelines

## Office Hours:

**Kingsport**
Monday thru Friday: 7:45 am – 4:45 pm

Injections given: 7:45 am – 4:15 pm

**Johnson City**
Wednesday: 8 am – 12 pm
1 pm – 5pm
Injections given: 8 – 11:30 am
1 – 4:30 pm

## Appointments

Please keep in mind that if you are more than **15** minutes late for your scheduled appointment, you may be asked to reschedule your visit.
If you cannot keep your appointment, please notify our office at least **24** hours in advance so that we can make this time available for other patients.

## Insurance Cards & Financial Responsibility

Co-pays must be paid at the time service is rendered. If you cannot pay your co-pay at this time, we can reschedule your appointment for a time that is more convenient for you.
It is your responsibility to know what your insurance will cover at this office. In the event that an insurance company determines charges are "non-covered" or "exceed the usual or customary rate", you may still be responsible for those charges.
If this office is not a preferred provider for your insurance, you will be responsible for all charges at the time services are rendered, and you will need to file your own insurance paperwork.
If your insurance requires a referral from your primary care provider, it is also your responsibility to get that referral.
If you do not have insurance, you will be responsible for all charges at the time services are rendered.
If you allow your account to be turned over to a collection agency, you will not be able to be seen by our physicians again until the account has been paid in full. Patients whose accounts have been turned over to a collection agency and/or have filed for bankruptcy will be seen on a cash only basis and will need to make arrangements regarding billing matters prior to seeing the physicians.

## Phone Calls & Emergencies

If you call this office after hours or over the weekends, you will get our answering service. One of the physicians or nurse practitioner will return your call as soon as possible, however if you have a medical emergency, go to the nearest emergency room or call 911.

## Medication and Refills

If you need a prescription or a prescription refill, please call during business hours and call **5** days before your prescription runs out.
If you are experiencing side effects to your medication or have any questions or concerns regarding your medication, please call during office hours.

## Miscellaneous Paperwork

If a patient needs Disability, Short Term Leave, Family Medical Leave, or any other type of paperwork/forms that the patient requests to be completed, there will be a **$15.00** charge. Same day requests will not be feasible. Fees will be collected before the paperwork is released. The only time this fee will be waived is if State of TN disability requests are sent to us by the State of TN.

## Social Security Numbers

In addition to our office, some insurance companies still use social security numbers as an identifier for patients. If you choose **not** to provide us with the patient's or insurance subscriber's social security number, you will be billed for the entire charge of the office visit on the day of service.

## Miscellaneous Info

- Be respectful of cell phone calls while you are the in the room with the physician. Ideally, cell phones should be turned off during the appointment.
- Bring a list of medications you are currently taking or have recently taken.

- There are times when patients would like to be seen sooner than we can schedule them. At your request, we can place you on a waiting list for the first available appointment time. If an opening becomes available, we will call the patients in the order they were placed on the list.

## Prescription Policy

- Pt will be given refills on their medications at time of office visits. However, in the event of missing an appointment or need to reschedule an appointment, refills may be provided for **1 month** only until another appointment is scheduled. Refills will not be called in over the weekends by doctors on call- only on Monday thru Friday during normal business hours (7:45 am – 4:45 pm).

- In the event of sickness and the doctor is called at night or over the weekends who prescribes a medication over the phone, a follow up appointment will need to be made on the next available day.

## No Show Policy

- If you cannot keep your appointment, please notify the office at least 24 hours in advance so that we can make this time available for other patients who need medical care.

- If you fail to show up for a scheduled appointment and have not called at least 24 hours in advance, a fee will be applied to your account in the amount of $25.00.

Sincerely,
W. Jan Kazmier, M.D., Ph.D.
Shailee Madhok, M.D.
& Staff

# REGIONAL
## ALLERGY ASTHMA & IMMUNOLOGY CENTER

2995 Fort Henry Drive
Kingsport, TN 37664
423-246-6445

2312 Knob Creek Road - Suite 206
Johnson City, TN 37604
423-246-6445

## Medical Information Release Form

## (HIPPA Release Form)

**Name:** _____ **Date of Birth:**____/___/_____

## Release of Information

( ) I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:

( ) Spouse_____

( ) Child(ren)_____

( ) Other_____

( ) Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

## Messages

Please call ( ) my home ( ) my work ( ) my cell Number:_____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date:____/___/_____

Witness:_____ Date:___/____/_____

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## OFFICE POLICIES & PROCEDURES ACKNOWLEDGMENT FORM

This acknowledges that I have received a copy of each of this office's Policies and Procedures, and I have been instructed to read and have read them in their entirety. I have been given an opportunity to review each policy, ask any questions I had about the material and receive explanation about it. I have been instructed to refer any further questions regarding the Policies and Procedures to the administrator/practice manager.

I understand that this office may make changes in the administration of Policies and Procedures, without notice, when such action is deemed necessary by the clinic administration. I understand that violation of clinic policy is case for action by office management up to and including discharge.

PATIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

# Regional Allergy & Asthma Center

2995 Ft. Henry Drive
Suite 100
Kingsport, TN 37664
(423) 246-6445

2312 Knob Creek Road
Suite 206
Johnson City, TN 37604
(423) 246-6445

## Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of Your Protected Health Information**

Your protected health information will be used by Regional Allergy & Asthma Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

**Notice of Privacy Practices**

Please review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

❑ accept ❑ deny

**Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your protected health information.

Regional Allergy & Asthma Center may or may not agree to restrict the use or disclosure of your protected health information.

If Regional Allergy & Asthma Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**

Regional Allergy & Asthma Center reserves the right to modify the privacy practices outlined in the notice.

**Signature**

**I have reviewed this consent form and give my permission to Regional Allergy & Asthma Center to use and disclosure my health information in accordance with it.**

| | |
|---|---|
| **Name of Patient (Print or Type)** | Signature of Patient Representative |
| Signature of Patient | Relationship of Patient Representative to Patient |
| Date | |

# List of Medications "NOT" To Be Stopped Prior Skin Testing

**Asthma Inhalers:**

Advair
Albuterol
Alvesco
Asmanex
Atrovent
Dulera
Flovent
Maxair
ProAir
Proventil
Pulmicort
Qvar
Symbicort
Xopenex

**Nasal Sprays:**

Flonase/Fluticasone
Nasacort
Nasonex
Omnaris
Qnasl
Rhinocort
Veramyst
Zetonna

Accolate
Singulair
Zyflo

* Antidepressants **(Except for: Tricyclic Antidepressants; e.g. Doxepin (Sinequan) and Nortryptyline).**

*ANY Blood Pressure Medications

**Proton Pump Inhibitors:**

Aciphex
Nexium
Prevacid
Prilosec
Protonix

## List of Antihistamines To Be Avoided Prior Allergy Skin Testing

** Avoid 2 weeks prior scheduled testing **

If unsure of a medication you are taking, check with your pharmacist.

(Over-the-Counter medications that may contain antihistamine: "Allergy", "Cold", "Flu" formulas)

Actifed
Alka-Seltzer Cold
Alavert
Allegra/Allegra-D
Antihist
Astelin/Astepro
Atarax (*5 days)
Atrohist
Axid
Azatadine
Benadryl (*5 days)
Bromfed
Brompheniramine
Cabinoxamine
Cerose DM
Cetirizine
Clemastine
Chlorpheniramine
Chlor-Trimeton
Clarinex/Clarinex-D
Claritin/Claritin-D
Codimal
Comtrex
Contac
Cyproheptadine
D.A. II Tablets
Deconamine
Dimenhydrinate
Dimetapp
Dimetane
Diphenhist
Diphenhydramine
Diphenylpyraline
Doxylamine (NyQuil)
Dristan
Drixoral
Duradryl
Dura-tab
Dura-Vent/DA
Extendryl
Efidac 24
Fedahist
Fexofenadine
Hydroxyzine
Hycomine
Kronofed
Loratidine
Meclizine (Antivert)
Methdilazine (HCl)
Naldecon
Nolahist
Nolamine
Novafed-A
NyQuil
Ornade
Patanase
Patanol/Pataday (*5 days)
Pedia-Care cough/cold
Pepcid
Periactin
Phenergan
Phenindamine (Nolamine)
Pheniramine (Polyhistine-D)
Poly-Histine-D
Promethazine
Pyrilamine
Robitussin (PM)
Rondec
Ryna Liquid
Trimeprazine
Trinalin
Triprolidine
Tylenol Allergy
Cold, Flu, PM
Vicks 44 cough/cold
Flu, PM
Vistaril
Xyzal
Zantac
Zyrtec/Zyrtec-D

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Please be advised of our "NO SHOW POLICY".

If you cannot keep your scheduled appointment date and time, please notify our office to reschedule as soon as possible (within at least 24 hours). This time should be made available for other patients who need medical care.

There will be a charge of $25.00 if you fail to show up for your scheduled appointment and/or discharged from the practice. This fee will be applied to your personal account.

Pt Name: _____ DOB: _____

Pt/Representative Signature: _____

Witness Signature: _____ Date: _____

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# PROCEDURE CONSENT FORM

I have been informed and am aware of the possible adverse reactions and complications involved with any procedure mentioned below. I have also been made aware of the importance of remaining on medical premises for the length of time required for the procedures. I therefore give my written consent to receive the following procedure (s).

Pt Name: _____ DOB: _____ Chart #_____

_____ _____
Patient/Guardian Signature Witness Signature

_____ _____
MD/FNP Signature Date

Inhalant/Food
Allergy Skin Testing _____

Anesthetic Testing
(e.g. Lidocaine) _____

Food Challenge
(e.g. milk, nuts, etc.) _____
Food: _____

Penicillin/Drug Testing _____

Drug Challenge
(e.g. aspirin) _____

Venom Testing _____

Chemical/Food Patch _____

CHART #_____

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Patient: _____ DOB: _____ Age: _____
Date:_____ Ethnicity: ❑ White ❑ African-American ❑ Asian ❑ Hispanic ❑ Other
Accompanied by: _____ Referring Physician: _____
Primary Care Physician: _____ Reason for Visit: _____

**Section A- Allergy Symptoms – Check ALL that apply- (If no allergy symptoms, proceed to Section B)**

| | | | |
|---|---|---|---|
| ❑ Itchy ears | ❑ Runny nose | ❑ Itchy eyes | ❑ Sore throat |
| ❑ Popping in ears | ❑ Sneezing | ❑ Watery eyes | ❑ Throat clearing |
| ❑ Ear pain | ❑ Nasal congestion | ❑ Red eyes | ❑ Hoarseness |
| ❑ Ear infections | ❑ Itchy nose | ❑ Swollen/puffy eyes | ❑ Loss of taste |
| ❑ Fluid in ears | ❑ Postnasal drip | ❑ Dark circles under eyes | ❑ Difficulty swallowing |
| ❑ Ear drainage | ❑ Nose bleeds | ❑ Eye drainage | ❑ Headache |
| | ❑ Decreased sense of smell | | ❑ Sinus pain/pressure |
| | ❑ Snoring | | ❑ Sinus infections |

When did your symptoms begin? _____
Worse in? ❑ Spring ❑ Summer ❑ Fall ❑ Winter ❑ All Year

How long have you had symptoms? _____ Are your symptoms getting worse? Y / N

Degree of symptoms? ❑ Mild ❑ Moderate ❑ Severe
Do they interfere with daily activities? Y / N

Where and when do your symptoms occur? ❑ Outdoors ❑ Indoors ❑ Home ❑ Work ❑ School
❑ Night ❑ Day ❑ Other

Which of the following make your symptoms worse? ❑ Pollen ❑ Grass ❑ Leaves ❑ Hay
❑ Cat ❑ Dog ❑ Dust ❑ Mold/Mildew ❑ Basements ❑ Horses ❑ Birds/Feathers
❑ Livestock ❑ Tobacco Smoke ❑ Pollution ❑ Aerosol sprays ❑ Perfumes ❑ Jewelry ❑ Colds/Viruses
❑ Air Condition/Heating ❑ Hot Weather ❑ Cold Weather ❑ Humidity ❑ Changes in Weather
❑ Other _____

Patient: _____ Chart: _____ DOB: _____

What makes your symptoms better? ❑OTC Meds ❑ Prescription Meds ❑ Nasal Spray
❑Antibiotics ❑Steroids ❑Travel ❑Air Condition ❑Rest ❑Other _____

Have you missed school/work due to your symptoms? Y / N Number of days missed on average? ____

Have you ever had Allergy Testing? Y / N Skin Test ❑ Blood Test ❑

How long ago was Allergy Testing performed? ❑Less than 1 year ❑1-3 years ❑4+ years
❑ Don't remember Did you every receive Allergy Shots ? Y / N

**Section B: Asthma Symptoms- Check All that apply-(If no asthma symptoms, proceed to Section C)**

Do you experience any of the following?

| | | |
|---|---|---|
| ❑Cough | ❑Symptoms with infections/colds | ❑Bronchitis |
| ❑Wheezing | ❑Symptoms with exercise | ❑Chest colds |
| ❑Shortness of Breath | ❑Symptoms at night | ❑History of RSV in infancy |
| ❑Chest Tightness | ❑Symptoms during the day | ❑Recurrent pneumonia |
| ❑Productive Cough | | ❑Recurrent walking pneumonia |

Are the above symptoms getting worse? Y / N How long have you had symptoms? _____

Do you consider your symptoms to be ❑Mild ❑Moderate ❑Severe?

Which of the following make your Asthma Symptoms worse?
❑Colds ❑Infections ❑Exercise ❑Animals ❑Sinusitis ❑Pollen ❑Mold/Mildew ❑Dust
❑Reflux ❑Cold Air ❑Cigarette Smoke ❑Changes in Weather ❑Other _____

How often do you require a Rescue Inhaler for your Asthma Symptoms?
Never ❑ 1-2 x per week ❑ 3-4 x per week ❑ Daily ❑ More than once a day ❑

How often in a typical week do your Asthma Symptoms wake you at night?
❑Never ❑1-2 x per week ❑3-4 x per week ❑Daily

In the past one (1) year, have you required steroids (oral, injectable)? Y / N
How often? ❑Once ❑Two (2) times ❑More than Three (3) times

Have you required any ER visits or Urgent Care visits due to Asthma Symptoms in the past one (1) year?
❑Never ❑1 time ❑2 times ❑3 times ❑More than 3 times
Have you required any hospitalizations due to Asthma Symptoms in the past one (1) year? Y / N
If yes, how many times? _____ ICU admissions? Y / N Intubations? Y/ N

Patient: _____ Chart: _____ DOB: _____

**Section C - Sinus Issues/Headaches (If none of these symptoms, proceed to Section D)**

Do you have Sinus problems? Y / N Number of Sinus Infections in past one (1) year? ____

Have you ever had an X-Ray or CT scan of your sinuses? Y / N
Have you ever had Sinus Surgery? Y / N Nasal Polyps? Y / N

Do you experience Headaches? Y / N How often do you have Headaches? ❑ Daily ❑ Weekly ❑ Monthly
How long do your Headaches last? ❑ Hours ❑ Days
Have you missed any school/work due to headaches? Y / N

What makes your Headaches better? ❑ Rest ❑ OTC Meds ❑ Prescription Meds ❑ Other _____

**Section D- Skin Symptoms: (If no skin symptoms, proceed to Section E)**

Do you experience any of the following: ❑ Rash ❑ Itching ❑ Eczema ❑ Hives ❑ Dry Skin ❑ Swelling of lips/face ❑ Skin Infections

Where do the Skin Rashes occur? _____

How long have you experienced Skin Symptoms? _____

Are Skin Symptoms getting worse? Y / N How often do Skin Symptoms Occur? _____

Have you been seen in Urgent Care or MD's office for your Skin Symptoms? Y/ N

Have you required Steroids (oral, injectable, topical) for your Skin Symptoms? Y / N How Often? _____

Which of the following make Skin Symptoms worse? ❑ Heat ❑ Cold ❑ Food ❑ Pets ❑ Metals ❑ Plants ❑ Medications ❑ Cosmetics ❑ Exercise ❑ Dry Weather ❑ Cleaning Supplies

What makes Skin Symptoms better? ❑ Steroid creams ❑ Antibiotics ❑ Lotion/Creams ❑ OTC Medications ❑ Oral/Injectable Steroids ❑ Avoidance of Food

Patient: _____ Chart: _____ DOB: _____

**Section E- Abdominal Symptoms : (If no abdominal symptoms, proceed to Section F)**

Do you have any of the following: ❑Abdominal Pain ❑Constipation ❑Diarrhea ❑Nausea
❑Heartburn/Reflux ❑Vomiting ❑Bloating - Other _____

**Section F- Other Allergy History : Check ALL that apply**

Do you get a rash with exposure to ❑Poison Ivy ❑Poison Oak ❑Poison Sumac?

Do you have a Food Allergy or Food Intolerance? Y / N (Please list suspected foods/reaction below)

_____

_____

Do you have a Latex Allergy? Y / N Type of Reaction? _____ When? _____

Do you have a Stinging Insect Allergy? Y / N (Please check insect/reaction below)
Honey Bee ❑ Reaction: _____ When? _____
Wasp ❑ Reaction: _____ When? _____
White-faced hornet ❑ Reaction: _____ When? _____
Yellow hornet ❑ Reaction: _____ When? _____
Yellow jacket ❑ Reaction: _____ When? _____
Mosquito ❑ Reaction: _____ When? _____
Fire Ant ❑ Reaction: _____ When? _____

Have you ever been prescribed Epi-Pen (self-injectable epinephrine)? Y / N

**Section G: Immune Problems**

Do you receive an annual Flu Shot ? Y / N Have you ever had a Pneumonia Shot? Y / N When? ____

Are your immunizations up to date? Y / N Do you have recurrent infections? Y / N

How often do you have infections? ❑Less than once a year ❑2-3 x per year ❑3-4 x per year

Have you been diagnosed to have an "Immune Deficiency"? Y / N

Patient: _____ Chart: _____ DOB: _____

**Past Medical History:** Please mark ALL that pertain to your history (past or present)

- ❑ ADD/ADHD
- ❑ Arthritis
- ❑ Autoimmune disorder
- ❑ Bipolar
- ❑ Bleeding Disorder
- ❑ Cancer
- ❑ Cataracts
- ❑ Chronic infections
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Gout
- ❑ Heartburn/reflux
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Problems
- ❑ Osteoporosis
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Thyroid Problems

Other _____

**Surgical History:** (Please list ALL previous hospitalizations/surgeries) Approximate Date

_____

_____

_____

_____

Have you had a Tonsillectomy? Y / N Adenoidectomy? Y / N Tympanostomy tubes (ears)? Y /N

**Medication List:** Dose: Frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Drug Allergies (Name):** Type of Reaction: When/Date:

_____

_____

_____

Patient Name: _____ Chart: _____ DOB: _____ Date: _____

**Family History:** (Mark any Family Members who have experienced any of the listed conditions.)

| Condition | Father | Mother | Brother/Sister | Grandparent | Uncle/Aunt |
|---|---|---|---|---|---|
| Allergy/Hay Fever | | | | | |
| Asthma | | | | | |
| Cystic Fibrosis | | | | | |
| Drug Allergy | | | | | |
| Eczema | | | | | |
| Emphysema | | | | | |
| Food Allergy | | | | | |
| Hives | | | | | |
| Immune Deficiency | | | | | |
| Insect Allergy | | | | | |
| Leukemia-Lymphoma | | | | | |
| Lupus | | | | | |
| Sinus Issues | | | | | |
| Thyroid Disease | | | | | |
| Tuberculosis | | | | | |

**Social History:**

Occupation _____ Type of Work _____

Hobbies _____

Personal Use of Tobacco : Y / N ❑Current ❑Past ❑Never Packs per day? _____

How many years of tobacco use? _____ Type of Tobacco _____

Secondhand exposure to smoke? Y / N Who? _____ How often? _____

Do you drink alcohol? Y / N How many drinks per week? _____ Recreational drug use? Y / N

**Environmental History:**

Do you have any pets? Y / N What kind? _____ Inside or Outside? _____

Do they sleep in your bedroom? Y / N

What exposure do you have at school/work? ❑Mold ❑Animals ❑Chemicals ❑Paint fumes ❑Smoke ❑Other _____

Any water leakage/damage in your home? Y / N Is there visible mold or musty odor? Y / N

Do you have ceiling fans? Y / N In bedroom ? Y / N

What type of flooring is in your home? ❑Carpet ❑Tile ❑Linoleum ❑Hardwood ❑Rugs

What type of Heating/Cooling is in your home ? _____ Window Unit _____Central Heat/Air _____ Space Heaters (radiators) _____ Other

How old is your home? _____

What type of window coverings? ❑None ❑Cloth ❑Drapes ❑Wood shutters ❑Blinds

If patient is a child, does he/she attend day care? Y / N

Patient: _____ Chart: _____ DOB: _____

**Review of Systems:**

General: ❑ Fever ❑ Chills ❑ Night Sweats ❑ Weight Gain/Loss ❑ Fatigue

Eyes: ❑ Burning ❑ Dryness ❑ Pain ❑ Vision Changes

HEENT: ❑ Headaches ❑ Nasal Symptoms ❑ Postnasal Drip ❑ Lip/Tongue Swelling

Cardio: ❑ Chest Pain ❑ Palpitations ❑ Irregular Heart Beats ❑ Rapid Heart Rate

Resp: ❑ Cough ❑ Wheezing ❑ Shortness of Breath ❑ Tightness in Chest

GI: ❑ Nausea ❑ Pain ❑ Vomiting ❑ Diarrhea ❑ Constipation

GU: ❑ Excessive Urination ❑ Pain/Burning with Urination ❑ Difficulty Urinating

Skin: ❑ Change in Existing Lesions/Moles ❑ New Lesions ❑ Itching ❑ Dryness

Neuro: ❑ Numbness/Tingling ❑ Tremors ❑ Developmental/Growth Delay

MS: ❑ Joint Pain ❑ Joint Swelling ❑ Athlete's Foot/Nail Fungus

Endocrine: ❑ Excessive Sweating ❑ Excessive Thirst ❑ Heat/Cold Intolerance

Psych: ❑ Anxiety ❑ Depression ❑ Stress

Lymph: ❑ Easy Bleeding ❑ Swollen Lymph Nodes/Glands

Immune: ❑ Recurrent Infections

**Vitals:** Wt. _____ Ht. _____ BP _____ Temp _____ RR _____ Pulse _____ 02 sat _____

Other: _____

_____

_____

_____

Patient: _____ Chart: _____ DOB: _____

For Physician Use Only: (Notes)

_____
_____
_____
_____
_____
_____

Physical Exam:

General _____
Skin _____
Eyes _____
Nose _____
Throat _____
Ears _____
Neck _____
Chest _____
Cardiac _____
Abdomen _____
Extremities _____
Ms/Neuro _____

Labs/Tests:

Skin test: ❑ Foods ❑ Inhalants ❑ Hymenoptera insects ❑ Other _____
Patch test: ❑ Foods ❑ Chemicals _____ Spirometry: ❑ Single ❑ Pre/Post
Blood test: ❑ RAST ❑ IgE ❑ Immune work-up ❑ Chronic Urticaria ❑ Titers
Radiology: ❑ X-Ray ❑ CT Scan

Diagnoses: _____
_____
_____
_____

Plan: _____
_____
_____
_____