# WELCOME

Date: _____

## Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

## Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

## Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE _____

# Health History

Who is your primary care physician? (doctor and/or practice) _____

**Please check to indicate if you are currently experiencing any of the following conditions:**

- ❑ Neck Pain Stiffness
- ❑ Back Pain Stiffness
- ❑ Arm Hand Pain
- ❑ Leg Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

**Please check to indicate if you have ever had any of the following:**

- ❑ Aids HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Other _____
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**) _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE (X)** _____ **DATE** _____

# Allergy Health Assessment

Patient Name: _____ DOB: _____

Were you referred by another doctor: ❑ Yes ❑ No Doctors Name: _____

Please check all recurrent symptoms:

| ***Nasal Symptoms*** | ***Sinus Symptoms*** | ***Chest/Throat Symptoms*** | ***Skin Symptoms*** |
|---|---|---|---|
| ❑ Runny nose | ❑ Post nasal drainage | ❑ Wheezing | ❑ Itching |
| ❑ Nasal congestion | ❑ Frequent throat clearing | ❑ Chest tightness | ❑ Eczema |
| ❑ Sneezing | ❑ Sinus pressure | ❑ Shortness of breath | ❑ Hives |
| ❑ Itchy eyes | ❑ Headache | ❑ Cough | ❑ Swelling |
| ❑ Watery eyes | ❑ Colored nasal mucous | ❑ Wheezing with exercise | ❑ Blisters |
| ❑ Itchy nose | ❑ Stuffy ears | ❑ Difficulty breathing at night | ❑ Contact allergy |
| ❑ Itchy ears | ❑ Frequent sinus infections | ❑ Frequent pneumonia | ❑ Other |
| ❑ Itchy throat | ❑ Bad breath | ❑ Throat tightness | ❑ _____ |
| ❑ Decreased taste or smell | ❑ Snoring | ❑ Hoarse voice | ❑ _____ |

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any seasonal variation in your symptoms and if so, when are they worse? ❑ Yes ❑ No

Nasal _____ Sinus _____ Chest _____ Skin _____

What medications have you tried for your allergy symptoms? Circle the ones that have helped.

_____

_____

**Your Environment**

What environmental triggers have made your symptoms worse?

❑ Mowed grass ❑ Windy weather ❑ Dust ❑ Spending time outdoors ❑ Moldy places ❑ Sweeping or dusting
❑ Cigarette smoke ❑ Pollen ❑ Insect sting ❑ Exercise ❑ Respiratory infections ❑ Weather changes ❑ Laughing
❑ Cold air ❑ Nighttime ❑ Stressful events ❑ Animals (specify) _____
❑ Perfumes, cosmetics, odors, etc. (specify) _____

How long have you lived in this area? _____ Where else have you lived? _____

Are you better or worse in this area? ❑ Better ❑ Worse

Do you have any pets? ❑ Yes ❑ No Please list: _____

Are symptoms worse when around your pet? ❑ Yes ❑ No Any previous pets in the home? ❑ Yes ❑ No

Any smokers in the home? ❑ Yes ❑ No Type of Home: ❑ Appartment/Condo ❑ House

Has your home had water or flood damage? ❑ Yes ❑ No

What kind of work do you do? _____ Are symptoms worse at work? ❑ Yes ❑ No

Have you travelled out of the country in the past year? ❑ Yes ❑ No Where? _____

Are there other households you visit frequently? ❑ Yes ❑ No Explain: _____

Family members with allergies/asthma? ❑ Mother ❑ Father ❑ Siblings

Please list all current medications including inhalers, over the counter medications, vitamins, and supplements:

_____

_____

_____

Any medications that you do not tolerate? ❑ Yes ❑ No If yes, list the medications and the reaction they caused:

_____

_____

_____

Any foods that you do not tolerate? ❑ Yes ❑ No If yes, list the foods and the reaction they caused:

_____

_____

## Medical History (check all that apply)

❑ Cataracts ❑ High blood pressure ❑ Acid reflux ❑ Stroke ❑ Glaucoma ❑ Coronary artery disease ❑ Irritable bowel
❑ Migraine headaches ❑ Hearing loss ❑ Irregular heart beat ❑ Inflammatory bowel disease ❑ Seizure disorder
❑ Frequent nose bleeds ❑ Enlarged heart ❑ Diabetes ❑ Kidney disease ❑ Nasal polyps ❑ Lung disease ❑ Thyroid disorder
❑ Cancer ❑ Fartubes ❑ Sleep apnea ❑ Pituitary disorder ❑ Arthritis ❑ Osteoporosis ❑ Other _____

## Previous Allergy Treatment

Other doctors seen for allergies: ❑ ENT ❑ Allergist ❑ Pulmonologist ❑ Dermatologist ❑ Gastroenterologist

Have you had nasal or sinus surgery? ❑ Yes ❑ No When and what were the results? _____

Have you been treated in urgent care or ER with asthma? ❑ Yes ❑ No Last Visit Date? _____

Have you had allergy tests? ❑ Yes ❑ No When and where? _____

Have you had allergy shots? ❑ Yes ❑ No When and where? _____

## Social History

Do you now or have you ever smoked? ❑ Yes ❑ No How much & how long? _____

Is there anything else you would like to share regarding your allergies?

_____

_____

_____

If you could fix one thing about your allergies, what would it be?

_____

_____

_____

## Office Use Only - Physician Assessment For Allergy

**Rule Out Contraindications:**

- ❑ Patients with poorly/uncontrolled asthma and reduced lung function
- ❑ Patients on Beta Blockers as this may inhibit the management of anaphylaxis
- ❑ Recent clinical history of anaphylaxis reaction to minute amounts of allergen
- ❑ Patients with advanced cardiovascular disease (Coronary Artery Disease and arrhythmias)
- ❑ For non-IgE-mediated asthma or rhinitis
- ❑ Patient is less than 5 years of age with inhalant therapy

Patient is taking a Beta-blocker? ❑ Yes ❑ No

**Patient's chief complaint:** _____

**Patient demonstrates symptoms of the following conditions:** _____

_____

_____

**Notes:** _____

_____

_____

_____

**Allergy skin testing is appropriate for this patient.** ❑ Yes ❑ No

**Physician's Signature:** _____ **Date:** _____