

Allergy & Immunology, PLC's  
**ASTHMA & ALLERGY CENTER**  
*Specializing in Allergic, Asthmatic & Sinus Conditions*

Telephone (540) 343.7331 Fax (540) 343-7349

Acct. # \_\_\_\_\_

**PATIENT INFORMATION SHEET**

Patient's Name (Please Print and include middle initial)		SS#	Marital Status S M W D Sep	Sex M F	Age	Birth Date
Street Address		City and State		Zip Code		Home Phone #
Patient's Employer (if child, go to next line)		Address		Work Phone#		Cell Phone #
Spouse's Name			Birth Date		SS#	
Spouse's Employer and address			Work Phone #		Cell Phone #	
Father's Name (if patient is a child)		Address			SS#	
Father's Employer and address			Work Phone #		Cell Phone #	
Mother's Name (if patient is a child)		Address			SS#	
Mother's Employer and address			Work Phone #		Cell Phone #	
Primary Care Physician		Address			Phone #	
Referring Physician		Address			Phone #	
How did you hear about our practice?		Drug Allergies:				
Name of Nearest Relative/Friend not listed		Address			Phone #	

PAYMENT AND INSURANCE INFORMATION				
Name of Primary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #
Name of Secondary Insurance	Policy Holder	Birth Date	Policy or ID #	Group #
Name of Third Insurance	Policy Holder	Birth Date	Policy or ID #	Group #

**INSURANCE AUTHORIZATION, ASSIGNMENT, AND ACKNOWLEDGEMENT:**

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for co-pays and deductibles when services are rendered unless other arrangements have been made in advance. Name of Policy Holder \_\_\_\_\_ I request that payment of authorized Insurance Company benefit be made either to me or on my behalf to Allergy & Immunology, P.L.C. for any services furnished me by this office. Regulations pertaining to Medicare assignment of benefits apply. I further understand that if my account has to be turned over to a Collection Agency for collection, I will be responsible for any additional collection fees. I further understand that I will be responsible for any fees associated with medical records being released for transfer of care, applying for new insurance, disability benefits, or other medical forms.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ALLERGY & IMMUNOLOGY, P.L.C. NEW PATIENT EVALUATION**

**SECTION I: CLINICAL HISTORY**

Nurse's Initials: \_\_\_\_\_

**1. Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Office Location:** \_\_\_\_\_

**S M D W**

**1. Chief Complaint:** Describe in the patient's own words, the problems that bring them here for evaluation.

- |  |   |
|--|---|
| <p>a) Have your health problems caused you to miss any work or school days over the past year? Yes / No If yes, how many? _____</p> <p>b) Have your family members missed any days of work or school because of your health problems? Yes / No If yes, how many? _____</p> <p>c) Have you required emergency treatments or hospitalization for this? Yes / No How many times in the past year? _____</p> <p>d) When did your main symptoms first appear?</p> | <p>e) When did the latest attack start and end?</p> <p>f) How often do you have these problems?</p> <p>g) How long do they last?</p> <p>h) Which of these symptoms do you have every day?</p> |
|--|---|

- 3. History of Present Illness: Oculo-Nasal**
- a) Do you have any eye or nasal symptoms? Yes/No If no, please skip item #4 below
- b) How long have you had these? \_\_\_\_\_

- 5. History of Present Illness: Pulmonary**
- a) Do you have any chest symptoms? Yes/No If no, please skip item #6 below
- b) How long have you had these? \_\_\_\_\_

**4. Check those eye or nasal symptoms that apply:**

**6. Check those "chest-related" symptoms that apply:**

Yes	None	Circle those symptoms that are most severe	Yes	None	Circle those symptoms that are most severe
		a) Runny nose / clear, watery			a) Chest tightness
		b) Blockage (plugged up)			b) Chest congestion
		Trouble with nose breathing			c) Frequent cough
		c) Sneezing spells or fits			Nocturnal cough
		d) Trouble smelling things			Cough with exertion
		e) Post-nasal drainage			Cough with laughing or screaming
		Thick, discolored drainage			Cough at rest
		Thin, clear, watery drainage			Coughing up discolored mucus
		f) Itching of eyes			Coughing up blood
		Of ears			d) Difficulty walking up stairs
		Of nose			Difficulty breathing
		Of throat			Trouble taking a deep breath
		Of roof of mouth			Shortness of breath
		g) Dryness or nose bleeds			Difficulty running
		h) Frequent colds or infections			Difficulty walking around
		Earaches or ear infections			Easy fatigability
		Sinus infections			e) Ever diagnosed as asthma
		i) Throat tickle with cough			f) Do you ever wheeze?
		j) Throat or face swelling			Hospitalized for wheezing
		k) Eyes - burning			Wheezing attacks
		Watery			Wheezing with colds
		Puffy or swollen eyes			Wheezing with exercise
		l) Frequent headaches			Wheezing at night
		Sinus headaches			Wheezing at rest
		Migraine headaches			g) Snoring
		Tension headaches			h) Mouth breathing

<b>7. Do you have any skin problems?</b> Yes / No If no, please mark "None" in the boxes to the right  <b>a) How long have you had these?</b> _____ if you have hives, welts, swelling, or urticaria, please complete the "Hives Questionnaire"  <b>b) Please describe your skin problem:</b>	<b>Check level of severity →</b>	<b>None</b>	<b>Mild</b>	<b>Mod</b>	<b>Severe</b>
	a) Generalized itching				
	b) Swelling				
	c) Eczema / Atopic dermatitis				
	d) Skin infections				
	e) Rash with metal				
	f) Poison ivy / oak / sumac				
	g) Psoriasis				
	h) Seborrhea				

**8. Do your symptoms vary with the seasons:** Yes / No If no, tell us if you have them all year or go to section #9

Mark the time of year when you have the following symptoms	All year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Nasal Symptoms													
Eye symptoms													
Chest symptoms													
Skin problems													
Other: (specify)													

**9. Please list any medications you may have taken recently or take on a regular basis and the dose.** (include OTC & BCPs) (If you need more space, list them in the unused blocks under item #10)

**10. Do you have any medication allergy or adverse reactions?** Yes / No If no, please skip this section.

Medication:	Dose taken	Last dose	Medication:	Reaction	When

**11. Have you ever been evaluated for allergies in the past?** Yes / No

a) If yes, to what tests were you found to be allergic?

b) Did you receive allergy injections? Yes / No

How long? Did they help? Yes / No

When were they stopped?

**12. Family History:** Circle those medical conditions which may run in your family.

List the relationship of the family member to you in the empty block next to the illness.

Aspirin reactions		Hay fever	
Bronchial asthma		Hiatal hernia	
Blocked nose		Hives	
Diabetes		Migraine headaches	
Eczema		Sinusitis	
Emphysema		Tuberculosis	
Food allergy		Other (specify)	

**Patient Name:**

**Date:**

**Nurse Initials:**

13. Check those factors below that make your symptoms worse		
	a) <b>Weather changes:</b> Rain, cold fronts, thunderstorms, wind	
	b) <b>Humidity:</b> High (dampness) or low (dryness)	
	c) <b>Tobacco smoke</b>	
	d) <b>Smog/air pollution</b>	
	e) <b>Cold air:</b> Inside (air conditioning) or outside	
	f) <b>Heat:</b> Inside or outside	
	g) <b>Perfumes, powder, detergents, air fresheners, hairspray</b>	
	h) <b>Fumes:</b> Paint, fuel, insecticides	
	i) <b>Bright sun</b>	
	j) <b>Inside dust:</b> Vacuuming, cleaning, sweeping, old books	
	k) <b>Outside dust</b>	
	l) <b>Stress, worry</b>	
	m) <b>Exercise or exertion</b>	
	n) <b>Laughing</b>	
	o) <b>Grass or hay mowing, fresh cut grass</b>	
	p) <b>Tree pollen</b>	
	q) <b>Mold:</b> Raking leaves, musty basements, mildew, fungi	
	r) <b>Weeds</b>	
	s) <b>Animals (list):</b>	
	t) <b>Feathers</b>	
	u) <b>Other:</b>	

14. **Home/Work Survey:** Circle those that apply. If "Yes," fill in the blank as appropriate.

**Occupation:**

Do any conditions at work make your symptoms worse? No / Yes \_\_\_\_\_

**Hobbies:** \_\_\_\_\_

Does anything related to your hobby make your symptoms worse? No / Yes **What?** \_\_\_\_\_

**Home heating:** furnace (gas coal oil electric) heat pump wood stove fireplace  
radiators baseboard space heaters forced air

**Home cooling:** none heat pump central electric evaporative (swamp cooler)  
fans window A/C unit

**Type of bed:** mattress & box spring waterbed foam & board **Mattress cover:** Yes / No

**Dust catchers:** stuffed animals shelves model airplanes

**Solid flooring:** wood tile vinyl concrete **Window covering:** drapes mini blinds shutters roll-up shades

**Carpets:** Yes / No wall-to-wall shag short pile berber deep pile throw rugs

**Pets:** Yes / No If you have pets, what kind and how many? \_\_\_\_\_

Are the pets indoor or outdoor? \_\_\_\_\_

Are you exposed to any other birds or animals? \_\_\_\_\_

Does anyone who lives at home smoke? Yes / No Who? \_\_\_\_\_

If you have smoked, how much and how long? \_\_\_\_\_

Are there any industries around that house that bother you? none papermill cement plant fabric mill  
farming other: \_\_\_\_\_

<b>15. If female, are you pregnant or trying to achieve pregnancy?</b> Yes / No <b>LMP:</b>				
<b>16. Ancillary Allergy History:</b>				
a) Do you have any problems with any foods? Yes / No Describe:				
b) Do you have any problems with insect stings? Yes / No What kind?				
Have you ever had any reactions that were more than large local swelling? Yes / No				
If "Yes," please complete the "Bee Sting Anaphylaxis Questionnaire."				
<b>17. Neonatal History:</b> (Circle appropriate answer)				
a) Were you breast-fed, bottle-fed, or both?				
b) Did you have problems with baby formulas? Yes / No If so, which ones?				
c) Were you premature? Yes / No				
d) Did you have newborn breathing problems? Yes / No				
<b>18. Immunizations:</b>				
a) Initial childhood immunization series	Yes / No	e) Typhoid	Yes / No	
b) Tetanus booster in 10 years	Yes / No	f) Pneumococcal vaccine	Yes / No	
c) Chicken pox vaccine	Yes / No	g) Prevnar	Yes / No	
d) MMR booster	Yes / No	h) Hepatitis B series	Yes / No	
		i) Influenza: (date of last dose) _____		
<b>19. Check those medical conditions which you have had in the past</b>				
<b>Review of Systems:</b>			<b>Past Medical History:</b>	
<b>Do you suffer from any of the following:</b>	<b>Frequency</b>	<b>Date of last episode</b>	<b>Have you had any of the following conditions:</b>	<b>When?</b>
Sinusitis			Nasal polyps	
Bronchitis			Emphysema	
Pneumonia			Tuberculosis	
Asthma attacks			Diabetes	
Bladder problems			Kidney disease	
Muscle or back trouble			Liver disease or hepatitis A, B, or C	
Arm or shoulder trouble			Carpal tunnel syndrome	
Arthritis			Cancer	
Tendonitis or joint trouble			Chicken pox	
Irregular heartbeat			Heart disease/rheumatic fever/murmur	
High blood pressure			Thyroid high low (circle)	
Alcohol use			Addiction	
Substance abuse			Sinus surgery	
Depression/nervous disorders			Sinus x-rays: yes/no Normal: yes/no	
Dizziness or vertigo			Sinus CT scan: yes/no Normal: yes/no	
Bleeding problems or easy bruising			Last chest x-ray	
Hiatal hernia/GERD			Hysterectomy	
Frequent heartburn or stomach ulcers			Nasal polypectomy	
Bedwetting			PE ear tubes, tonsil or adenoidectomy	
Seizures/convulsions			Other Surgeries:	
Hair loss				
<b>19. Additional Comments:</b>				
<b>Physician's Signature:</b> _____				
<b>Date:</b> _____				