

Contact: _____ Relationship: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Signature of Patient or Responsible Party: _____ Date: _____

I request payment be made to Allergy/Asthma Specialists W. MI. The undersigned is responsible for all fees, regardless of insurance coverage. A copy of this authorization is as valid as the original.

Signed: _____
(Patient or responsible party)

Date: _____



*****ONLY SIGN THIS SECTION IN OUR OFFICE AT CHECK-IN**

I acknowledge that I have received a copy of the Notice Regarding Privacy of Personal Health Information of Allergy/Asthma Specialists W. MI.

Signed: _____
(Patient or responsible party)

Date: _____

PLEASE COMPLETE BEFORE YOUR APPOINTMENT

NAME: _____ **Date:** _____ **Primary care provider:** _____

1 Circle 3 to 5 most bothersome NASAL / EYE SYMPTOMS: (IF NONE, SKIP)

- Runny nose Stuffy nose Sneezing Discolored nasal discharge throat clearing
- Post nasal drip Itchy nose Rubbing nose Loss of smell Loss of taste
- Mouth breathing Snoring Sniffing Red eyes Cough
- Itchy eyes Watery eyes Dry eyes Puffy eyes Rubbing eyes
- Headaches

Other: _____

***How long have you had these symptoms?** _____

Medications tried for nose and eye symptom: (pills, nasal sprays, eye drops, other)

Name of drugs	How long tried?	helped	Some help	No help

2 Ever diagnosed with ASTHMA? (circle) NO / YES- when diagnosed: _____

- IF NO, Ever been given asthma medications, inhalers, breathing treatments? NO / YES

✓ *If YES*, which ones: _____

Circle up to 5 most bothersome CHEST SYMPTOMS: (IF NONE, SKIP to 3)

- Trouble breathing Chest tightness Frequent cough Cough at night Wheezing
- Morning cough Cough or wheeze with exercise/play Cough after eating Rattly chest

Other: _____

-Does exercise/activity trigger cough or wheeze? (circle) NO / Sometimes / Often

-Typically has nighttime or early morning cough NONE/ _____(enter#) times a week.

- Any HOSPITALIZATIONS for **asthma** or other **breathing** problems? NO / YES

✓ *IF YES*: How many times? _____ When was that last time? _____
 Ever in ICU (intensive care unit)? NO / YES when? _____

- Any ER/URGENT CARE visits for **asthma** or other **breathing** problems? NO / YES

✓ *IF YES*: How many times? _____ When was that last time? _____

- Any PREDNISONE / ORAL STEROID PILLS or syrups for **breathing** flare? NO / YES

✓ *IF YES*: How many times? _____ When was that last time? _____

- **Quick relief inhaler used** (like Albuterol, Proventil, Ventolin, Maxair) _____ times a month / week / day

- **Spacer?** No Yes with mouthpiece with facemask

- Does the Quick Relief inhaler help? NO / YES

- **Peak Flow Meter?** No Yes, typically runs _____ .

3 Symptoms are: Year-round OR/AND Worse during (circle months)

NOSE/EYES: Year Round / Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Chest/Asthma: Year Round / Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4 ALLERGY SURVEY

a. Previous Allergic Investigation –

By whom _____ When _____
Results of test _____
Immunotherapy No Yes → Any significant reactions? No Yes → _____
Duration _____ Did shots help? _____
Reason Treatment stopped _____

b. Occupational History—

Employer _____
Specific Job _____
Difference in symptoms at work/home _____
Change in symptoms on vacation _____

IF CHILD:
In Daycare/Preschool? _____
Since when? _____
_____ days per week

c. Living Accommodations –

House Apartment Mobile Home • City Town Country
Age of home _____ Years lived in this location _____
Prior occupants with pets? No Yes: _____
Basement: Yes No • Finished Carpet Damp Dry Dirt
Heating: Forced Air Space Heat Hot Water Wood Burn Gas Electric
Air Conditioning: Yes No • Central Unit Room
Humidifier: Yes No • Central Unit • Dehumidifier: Yes No

Bedroom—
Sleeps on: Mattress Waterbed
Pillow: Foam Feather Polyester
Stuffed Animals in bedroom: Yes No
Floor: Carpet Wood Linoleum

Living Room—
Floor: Carpet Wood Linoleum

(Continued)—
Water leak problems No Yes:
Obvious mold problems No Yes:

d. Pets? – YES NO

Outdoors Indoors What kind? _____
How long have you had the pets? _____

Exposure to friends'/relatives' pets? What kind? _____
Symptoms around pets: _____

e. Smoking Exposure? – YES NO

Patient Father Mother Spouse Others
Prior smoking? No Yes: how long ___ yrs; packs per day ___ When stopped: _____

f. Allergy to Food? – YES NO

Food _____ Reaction: _____
Food _____ Reaction: _____

g. Allergy to Medications? – YES NO

Medication _____ Reaction: _____
Medication _____ Reaction: _____

h. Severe Insect Stings Reactions?— YES NO NEVER BEEN STUNG

Large Swelling Hives on other parts of the body Breathing problems Dizziness or fainting
 Other: _____

5 Check triggers:

Nose/Eyes
Chest

Nose/Eyes
Chest

Nose/Eyes
Chest

Dust			Tobacco smoke			Food		
Mowed grass			Colds/Viruses			Exercise		
Pets: (what kinds)			Strong Odors			Cold air		
			Wind			Humid days		
Weather changes			Stress			Air conditioning		
Others:			Raking leaves			perfumes		

Family history (please check all that apply):

	Father	Mother	Brother(s)	Sister(s)	Children
Migraine					
Hives					
Emphysema					
Asthma					
Eczema					
Hayfever/Nasal Allergies					
Thyroid Disease					

6 LIST ALL CURRENT MEDICATIONS & SUPPLEMENTS and how often you take them.

7 REVIEW OF SYSTEMS: (Please circle all that pertain):

- Heart:** Heart murmurs palpitations irregular heartbeat other heart conditions
GI: Heart burn/reflux Diarrhea constipation gas abdominal pain cramps bloating
GU: Bedwetting incontinence frequency urgency
Skin: Diaper rash cradle cap thrush eczema hives
Hives: Triggers- stress cold exercise hot shower vibration pressure points sun

8 PAST MEDICAL HISTORY: (Please circle all that pertain)

Nasal polyps / Facial Trauma /Migraines / Frequent Sinusitis / Thyroid Problems / Stomach Acid Reflux / Tuberculosis /
 Compromised immune system /Heart Disease / High Blood Pressure / Arthritis / Joint Problems / Osteoporosis

If A Child: Pregnancy/delivery: Full-term / Premature Growth and Development: Normal / Vomiting / Spitting

Immunizations: Up-to-date / Flu shot / Pneumovax/ missing: _____]

Surgeries: tonsils / adenoids / sinuses / ear tubes / other: _____

Hospitalizations: _____ **ER Visits:** _____

Any Other Important Medical History?: _____

*****Please bring in ANY INHALERS, PEAK FLOW METERS, AND SPACERS.*****