

ADDITIONAL NOTES

ALL CURRENT MEDICATIONS

| | | | | | |
|--|---|-------|-------|-------|------------------|
| Include nasal sprays & inhalers, prescription, over-the-counter, herbal, etc. | Number of mg, tabs, caps, or inhaler puffs | | | | Is it effective? |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

PREVIOUS ALLERGY / ASTHMA MEDS

(Include inhalers, nasal sprays, over-the-counter, herbal, etc. Indicate side effects, if any)

Circle if tried: Allegra Claritin Zyrtec

CURRENT ENVIRONMENT (check those that apply)

| | | | | |
|--|--------------------------------------|---|--|------------------|
| Home Location | Home Type | Basement | Air-Treatment | |
| <input type="checkbox"/> City | <input type="checkbox"/> House | <input type="checkbox"/> None | <input type="checkbox"/> Forced Air Heat | _____ |
| <input type="checkbox"/> Suburban | <input type="checkbox"/> Apartment | <input type="checkbox"/> Full | <input type="checkbox"/> Hot Water Heat | _____ |
| <input type="checkbox"/> Rural | <input type="checkbox"/> Condo | <input type="checkbox"/> Crawl Space | <input type="checkbox"/> Woodburner | _____ |
| <input type="checkbox"/> Near Farm | <input type="checkbox"/> Modular | <input type="checkbox"/> Dry | <input type="checkbox"/> Air Filter | _____ |
| <input type="checkbox"/> Near Water | <input type="checkbox"/> Mobile | <input type="checkbox"/> Wet | <input type="checkbox"/> Central AC | _____ |
| <input type="checkbox"/> Near Woods | _____ years there | <input type="checkbox"/> Dehumidifier | <input type="checkbox"/> Humidifier | _____ |
| | _____ years old | <input type="checkbox"/> Mold Growth | <input type="checkbox"/> Smoking in Home | _____ |
| Bedroom | Bed | Pets | How Many? | How Long? |
| <input type="checkbox"/> Main Floor | <input type="checkbox"/> Box Spring | <input type="checkbox"/> Cats | _____ | _____ |
| <input type="checkbox"/> Basement | <input type="checkbox"/> Futon | <input type="checkbox"/> Dog | _____ | _____ |
| <input type="checkbox"/> Carpeted | <input type="checkbox"/> Crib | <input type="checkbox"/> Bird | _____ | _____ |
| <input type="checkbox"/> Wood Floor | <input type="checkbox"/> Foam Pillow | <input type="checkbox"/> Rodent | _____ | _____ |
| <input type="checkbox"/> Stuffed Animals | | <input type="checkbox"/> Other | _____ | _____ |
| | | <input type="checkbox"/> Symptoms from Animals | | |
| | | <input type="checkbox"/> Pets indoors | <input type="checkbox"/> Pets sleep in bed | |
| | | <input type="checkbox"/> Allergy Encasings on bedding | | |
| | | <input type="checkbox"/> Cockroaches Seen | | |

PREVIOUS ALLERGY HISTORY

| | | | |
|---|--------------------------|--------------------------|-------|
| | YES | NO | |
| Previous allergy testing? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| If YES then answer the questions below | | | |
| Testing by Dr: _____ Year: _____ | | | _____ |
| Previous allergy shots? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Still on allergy shots? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Allergy shots help _____% (0-100) | | | _____ |
| Reactions to allergy shots? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Describe: _____ | | | _____ |
| Why were shots discontinued? _____ | | | _____ |
| _____ | | | _____ |

Provider: _____

PAST MEDICAL HISTORY

ADDITIONAL NOTES

Hospitalizations

| | |
|-------------|---------|
| Age or Year | Illness |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Surgeries

| | |
|--|--|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Ear Tubes |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Sinus / Nasal Surgery |
| Other _____ | |

Emergency Visits

_____ times in past year for _____

_____ times in past 5 years for _____

Chronic Health Conditions

| | |
|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Depression |
| Other _____ | |

SOCIAL HISTORY

Occupation / School Grade: _____

Where & How long: _____

Symptoms at work: _____

Hobbies: _____

Level of education: _____

Travel in past year? Where? _____

Do you have children in day care? How many? _____

 With how many other kids? _____

 Are there animals there? _____

 Smokers? _____

Other relevant social factors: _____

| Marital Status | Life Stress | History of: | YES | NO |
|------------------------------------|--|--------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Family | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Married | <input type="checkbox"/> Financial | Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> School | HIV (AIDS test) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Work | Recreational Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Nervous Tension | Alcohol Use | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Partner | | | | |

| Smoking | Recent | Date | Positive? |
|---|---------------------------------|-------|-----------|
| <input type="checkbox"/> Never Smoked | Chest X-Ray | _____ | _____ |
| <input type="checkbox"/> Current Smoker | Sinus X-Ray | _____ | _____ |
| <input type="checkbox"/> Former Smoker | Cat Scan | _____ | _____ |
| Packs / day _____ | TB (PPD) test | _____ | _____ |
| Years Smoked _____ | Pneumonia shot | _____ | _____ |
| Date quit _____ | Flu shot | _____ | _____ |
| Smoke exposure in home? _____ | If child, vaccinations current? | _____ | _____ |
| Smoke exposure at work? _____ | | | |
| Other tobacco _____ | | | |

Provider: _____

MISCELLANEOUS Please answer the following as well as possible

% of days per year you have allergy symptoms (0-100%) _____ Number of head or chest colds per year _____
 % of those days medication is used (prescription or OTC) _____ Number of visits to doctor, med center or ER for treatment _____
 Steroid (cortisone) pills or shots used to treat allergy or asthma? _____ Number of missed school or work days for colds _____
 Number of antibiotics per year for head or chest colds _____ Sinus infections _____ Ear infections _____ Total _____

FAMILY HISTORY

Allergies Asthma Frequent Cough Alive Deceased

| | | | | | |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Birth Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| # of Sister(s) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| # of Brother(s) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grandfather(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grandmother(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| # of Children _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

List other chronic family conditions such as eczema, sinusitis, hives, cystic fibrosis, emphysema, cancer, diabetes, frequent infections, immunodeficiency, thyroid, autoimmune, etc. _____

HAVE YOU EXPERIENCED

CONSTITUTIONAL

Fever
 Sweats
 Heat intolerance
 Cold intolerance
 Headache
 Negative
 Other: _____

EARS

Plugged ears
 Multiple infections
 Decreased hearing
 Negative
 Other: _____

NOSE

Plugged nose
 Multiple infections
 Congested
 Sneezing
 Runny nose
 Nasal polyps
 Nose bleeds
 Decreased smell
 Negative
 Other: _____

THROAT

Congested
 Sore throat
 Hoarseness
 Negative
 Other: _____

EYES

Itchy
 Watery
 Cataracts
 Glaucoma
 Negative
 Other: _____

CARDIOVASCULAR

Chest tightness
 High blood pressure
 Negative
 Other: _____

RESPIRATORY

Cough
 Wheeze
 Sputum production
 Shortness of breath
 Negative
 Other: _____

GASTROINTESTINAL

Vomiting
 Heartburn
 Diarrhea
 Bloating
 Poor appetite
 Constipation
 Gas
 Negative
 Other: _____

ALLERGY/IMMUNOLOGY

Hay fever
 Sinus problems
 Gland swelling
 Negative
 Other: _____

SKIN

Rash
 Hives
 Dryness
 Itching
 Negative
 Other: _____

ENDOCRINE

Hyperthyroid
 Hypothyroid
 Diabetes
 Negative
 Other: _____

PSYCH

Anxiety
 Sleep disturbance
 Lack of energy
 Negative
 Other: _____

IF YOU HAVE WHEEZE, COUGH, SHORTNESS OF BREATH, CHEST TIGHTNESS OR PAIN, OR ASTHMA

Score

- In the past 4 weeks, how much time did your symptoms keep you from getting as much work done at work, school, or home?**
 (1) All the time (2) Most of the time (3) Some of the time (4) A little of the time (5) Never
- During the past 4 weeks, how often have you had shortness of breath?**
 (1) More than once/day (2) Once per day (3) 3-6 times a week (4) Once or twice a week (5) Not at all
- During the past 4 weeks, how often did these symptoms wake you up at night or earlier than usual in the morning?**
 (1) 4 or more nights per week (2) 2-3 nights/week (3) Once per week (4) Once or twice (5) Not at all
- During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?**
 (1) 3 or more times/day (2) 1-2 times/day (3) 2-3 times/week (4) Once per week (5) Not at all
- How would you rate your asthma symptom control during the past 4 weeks?**
 (1) Not controlled (2) Poor control (3) Somewhat controlled (4) Well-controlled (5) Complete Control

Circle if you have ever had Emergency room visits / Hospitalization / Intubation / Difficulty taking asthma medications

Provider: _____

Appointment Date: _____

Check In Time: _____

How did you hear about us?

- Doctor
 NP
 PA
 Newspaper

- Phonebook
 Insurance Website
 Our Website
 Friend/Family (name) _____

Patient Information - Please print clearly

M F

First Name _____ Middle _____ Last Name _____ Sex _____ Age _____ Race _____ Date of Birth _____ / /

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Home Phone _____ Cell Phone _____ Drivers License # _____ () -

Employer and/or College Name _____ Employer's Address _____ Work/School Phone Number _____ () -
 Single Married Divorced Widow - Spouse's Name: _____ Spouse's Phone Number _____ () -

Emergency Contact Person's Name _____ Relationship to the Patient _____ Emergency Contact's Phone Number _____

Guarantor / Responsible Party _____ Address _____
 Social Security Number _____ Date of Birth _____ Relationship to the Patient _____

Primary Care Physician's Name _____ Address _____ Phone Number _____

Referring Physician/Physician Assistant/Nurse Practitioner Name _____

Current Pharmacy: _____ Where? _____ Phone Number: _____ Fax Number: _____

May we contact you by e-mail? YES NO E-mail address: _____ (Presently, we are not reachable via e-mail.)

Preferred Contact: Cell Phone Home Phone Email Text Message Mail May we invite you to the patient portal? YES NO

- Language** English Spanish Other
- Race** American Indian or Alaskan Native Asian Black or African American Native Hawaiian White
- Ethnicity** Hispanic or Latino Non Hispanic or Latino Undetermined

Primary Insurance for the Patient

Secondary Insurance for the Patient

Insurance Company Name _____

Contract Number _____ Group Number _____

Policy Holder's Name _____

Address _____

City _____ State _____ Zip Code _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security Number _____ () -

Policy Holder's Home Phone Number _____ Policy Holder's Cell Phone Number _____

Employer's Name _____ Policy Holder's Drivers License Number _____

Employer's Address _____ Employer's Phone Number _____

HRA HSA Flex Other _____

Insurance Company Name _____

Contract Number _____ Group Number _____

Policy Holder's Name _____

Address _____

City _____ State _____ Zip Code _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security Number _____ () -

Policy Holder's Home Phone Number _____ Policy Holder's Cell Phone Number _____

Employer's Name _____ Policy Holder's Drivers License Number _____

Employer's Address _____ Employer's Phone Number _____

HRA HSA Flex Other _____

Complete the following ONLY IF PATIENT IS A MINOR CHILD OR A COLLEGE STUDENT - Please print clearly

Full time college student Part time college student

Mother / Father / Domestic Partner _____ Middle Initial _____ Last Name _____ Home Phone _____ Cell Phone _____ () - () -

Mother / Father / Domestic Partner _____ Address _____ City _____ State _____ Zip Code _____ () - () -

Mother / Father / Domestic Partner _____ Middle Initial _____ Last Name _____ Home Phone _____ Cell Phone _____ () - () -

Mother / Father / Domestic Partner _____ Address _____ City _____ State _____ Zip Code _____

With whom does the child live? Mother Father Both Other (please specify) _____

THESE MEDICATIONS INTERFERE WITH ALLERGY TESTING
PLEASE READ CAREFULLY

24 HOURS BEFORE

Stop for 24 hours prior to testing:

- Skin cream or lotion on the back and arms
- Singulair (montelukast), Accolate, Benadryl (diphenhydramine)

7 DAYS BEFORE

Stop for 7 days prior to testing:

- Over the counter – cold/cough/sinus preparations, medications which contain doxylamine, diphenhydramine, chlorpheniramine, fexofenadine, loratadine, cetirizine, any antihistamine, any antihistamine/decongestant combination or homeopathic allergy supplement
- Antihistamine (examples) Actifed, Alavert, Alka-Seltzer Allergy, Allegra, Antivert, Atarax (hydroxyzine), Atrohist, Bromfed, cetirizine, Clarinex, Claritin, Comhist-LA, D.A.Chewable, Deconamine, Dimetane DC, Doxepin, Extendryl, Fedahist, fexofenadine, Histex, Kronafed-A, loratadine, Meclizine, Nolahist, Nalamine, PBZ, Periactin, Phenergan, RuTuss, Rynatan, Rynatuss, Sinulin, Tavist, Teldrin, Temaril, Triaminic, Trinalin, Tussionex, Vistaril, Xyzal, Zyrtec
- Eyedrops – Pataday, Zaditor, Optivar, Elestat, over the counter allergy drops
- Reflux/Ulcer medicines – if possible, discontinue Tagamet, Zantac/ranitidine, Pepcid, Acid, Cimetidine. If not possible to stop reflux/ulcer meds for 7 days, they should be stopped for a minimum of 24 hours.
- Sleep aids – Sinequan, Bufferin AT Nite-Time, Excedrin PM, Unisom, Advil PM, Tylenol PM
- Nasal Spray – Astelin, Astepro, Patanase, Dymista
- Steroids – long-term or high-dose prednisone may partially suppress skin tests
- Motion Sickness/anti-nausea medications

YOU MAY CONTINUE TO TAKE THESE MEDICATIONS

- Do **NOT** discontinue asthma medications (asthma inhalers, theophylline products, prednisone)
- Plain decongestants (Sudafed, pseudoephedrine, phenylephrine)
- Topical decongestant (Afrin nasal spray)
- Topical nasal moisturizer – Ocean, Ayr (saline)
- Topical non-antihistamine nasal sprays
- Over the counter Nasalcrom, Flonase, Nasacort
- Prescription Atrovent, Omnaris, Nasarel, Nasonex, Rhinocort, Zetonna, Qnasl
- Antibiotics
- Oral pain medications – Motrin, ibuprofen, Tylenol Sinus (if decongestant ONLY)
- Prevacid (lansoprazole), Prilosec (omeprazole)
- Do NOT discontinue medicines used for other disease processes unless specified above.

The office is located at 970 Parchment Drive, S.E., just off Cascade Road, S.E.

If you are traveling from the north, take Interstate 96 East to Exit 40 for *Cascade Road*. Follow sign for *Cascade Road East* to merge onto Cascade Road. Continue east (right lane) approximately a block and a half, then turn right onto Parchment Drive. The office is directly behind the 5/3 Bank.

When traveling from the south, take Interstate 96 to Exit 40 for *Cascade Road*. Follow the sign for *Cascade Road East* to merge onto Cascade Road. Continue east (right lane) approximately a block and a half, then turn right onto Parchment Drive. The office is directly behind the 5/3 Bank.

We look forward to seeing you at Grand Rapids Allergy
Drive Safely