GRAND RAPIDS ALLERGY 970 Parchment Dr. S.E. Grand Rapids, MI 49546 P.616.949.4840 F. 616-949-3531 www.grandrapidsallergy.com

Appointment Date: _____
Check In Time: _____

How did you hear about us?
- ☐ Doctor
- ☐ NP
- ☐ PA
- ☐ Insurance Website
- ☐ Grand Rapids Allergy Website
- ☐ Friend/Family (name) _____

Patient Information - Please print clearly

First Name | Middle | Last Name | Sex at birth (M F) | Age | Date of Birth (/ /)

Preferred Name | Pronouns | Gender identity

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 Race Ethnicity

- ☐ English ☐ Spanish ☐ Other
- ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White
- ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Undetermined

Primary 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 _____

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 _____

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) _____

GRAND RAPIDS Allergy

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, Nolamine, 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, Axid, 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

Grand Rapids Allergy 970 Parchment Drive SE Grand Rapids, MI 49546 Phone: (616) 949-4840 Fax: (616) 949-3531 www.grandrapidsallergy.com

PATIENT PLEASE FILL OUT ALL PAGES

Referring Physician: _____
City: _____
Chief Problems Are: _____
Goal for visit? _____

Please check associated symptoms: YES NO

	YES	NO
Runny nose	☐	☐
Nasal congestion	☐	☐
Postnasal drip / sore throat	☐	☐
Frequent yellowish nasal drainage	☐	☐
History of nasal polyps	☐	☐
Itchy or watery eyes	☐	☐
Ears plug / itch / pain / reduced hearing	☐	☐
Sneezing	☐	☐
Headaches	☐	☐
Eczema	☐	☐
Wheezing	☐	☐
Cough	☐	☐
w/exercise	☐	☐
during the night	☐	☐
for weeks after colds	☐	☐

Diagnosis of asthma made _____ years ago.
Number of past hospitalizations for asthma: _____
Number of past emergency visits for asthma: _____
Days of school or work missed in past year: _____

Food Allergy ☐ None. If yes, describe: _____

Latex Reactions ☐ None ☐ Gloves ☐ Balloons
☐ Dental Visits ☐ Vaginal Exams ☐ Kiwi ☐ Banana

Bee Sting Reactions ☐ None ☐ Never Stung
☐ Local Swelling ☐ Respiratory ☐ Other

Drug Allergy ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin
Other _____
Explain _____

Nickel / Metal Reactions ☐ None.
Explain _____

Other Allergy ☐ None.
Explain _____

TIMING OF SYMPTOMS: Check all that apply
☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Days / weeks at a time ☐ All the time ☐ At Home
☐ All day ☐ Outside ☐ At work / school
☐ Worse at night ☐ Worse in A.M.

SYMPTOMS ARE MADE WORSE BY:

☐ Dusting or cleaning
☐ Garage sweeping
☐ Mowing grass
☐ Raking leaves
☐ Hay / Straw / Barns
☐ Dogs
☐ Cats
☐ Aerosol spray
☐ Newspaper
☐ Smoke
☐ Odors / Perfume
☐ Exercise
☐ Cold air
☐ Damp air

Other (explain): _____
_____

GRAND RAPIDS Allergy

Patient Legal Name: _____
Preferred Name: _____
Pronouns: _____
Date of Birth: _____
Date of Appointment: _____
Form completed by (circle): Self Spouse
Parent / Guardian (name): _____

ADDITIONAL NOTES **Describe Problem**

Date of Onset: _____
Duration: _____
Severity: _____

Provider: _____

ALL CURRENT MEDICATIONS

ADDITIONAL NOTES

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

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
- ☐ City
- ☐ Suburban
- ☐ Rural
- ☐ Near Farm
- ☐ Near Water
- ☐ Near Woods

Home Type
- ☐ House
- ☐ Apartment
- ☐ Condo
- ☐ Modular
- ☐ Mobile
- ___ years there
- ___ years old

Basement
- ☐ None
- ☐ Full
- ☐ Crawl Space
- ☐ Dry
- ☐ Wet
- ☐ Dehumidifier
- ☐ Mold Growth

Air-Treatment
- ☐ Forced Air Heat
- ☐ Hot Water Heat
- ☐ Woodburner
- ☐ Air Filter
- ☐ Central AC
- ☐ Humidifier
- ☐ Smoking in Home

Bedroom
- ☐ Main Floor
- ☐ Basement
- ☐ Carpeted
- ☐ Wood Floor
- ☐ Stuffed Animals

Bed
- ☐ Box Spring
- ☐ Futon
- ☐ Crib
- ☐ Foam Pillow

Pets	**How Many?**	**How Long?**
☐ Cats		
☐ Dog		
☐ Bird		
☐ Rodent		
☐ Other		

- ☐ Symptoms from Animals
- ☐ Pets indoors ☐ Pets sleep in bed
- ☐ Allergy Encasings on bedding
- ☐ Cockroaches Seen

PREVIOUS ALLERGY HISTORY

	YES	NO
Previous allergy testing?	☐	☐

If YES then answer the questions below

Testing by Dr: _____ Year: _____

Previous allergy shots?	☐	☐
Still on allergy shots?	☐	☐

Allergy shots help _____% (0-100)

Reactions to allergy shots?	☐	☐

Describe: _____

Why were shots discontinued? _____

Provider: _____

PAST MEDICAL HISTORY

Hospitalizations

Age or Year _____ Illness _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgeries

☐ Tonsillectomy ☐ Ear Tubes
☐ Adenoidectomy ☐ Sinus / Nasal Surgery
Other _____

_____

Emergency Visits

____times in past year for _____

____times in past 5 years for _____

Chronic Health Conditions

☐ Hypertension ☐ Heart Disease
☐ Diabetes ☐ Migraines
☐ GERD (reflux) ☐ Depression
Other _____

_____

SOCIAL HISTORY

Ocupation / 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

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Separated
☐ Partner

Life Stress

☐ Family
☐ Financial
☐ School
☐ Work
☐ Nervous Tension

History of:	YES	NO
Hepatitis	☐	☐
Blood Transfusion	☐	☐
HIV (AIDS test)	☐	☐
Recreational Drugs	☐	☐
Alcohol Use	☐	☐

Smoking

☐ Never Smoked
☐ Current Smoker
☐ Former Smoker
Packs / day _____
Years Smoked _____
Date quit _____
Smoke exposure in home? _____
Smoke exposure at work? _____
Other tobacco _____

Recent	Date	Positive?
Chest X-Ray	_____	_____
Sinus X-Ray	_____	_____
Cat Scan	_____	_____
TB (PPD) test	_____	_____
Pneumonia shot	_____	
Flu shot	_____	

If child, vaccinations current? ____

ADDITIONAL NOTES

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		☐	☐	☐	☐	☐
Birth Mother		☐	☐	☐	☐	☐
# of Sister(s)	____	☐	☐	☐	☐	☐
# of Brother(s)	____	☐	☐	☐	☐	☐
Grandfather(s)		☐	☐	☐	☐	☐
Grandmother(s)		☐	☐	☐	☐	☐
# of Children	____	☐	☐	☐	☐	☐

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
- ☐ Constipation
- ☐ Abdominal pain
- ☐ IBS

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

1. 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 ☐

2. 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 ☐

3. 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 ☐

4. 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 ☐

5. 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: _____