

**PATRICIA E. JONES, M.D. ALLERGY & ASTHMA CENTER, P.C.**

232 NE TUDOR ROAD  
LEE'S SUMMIT, MO 64086  
816-246-2131

Patient \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Welcome to our practice. Please read the contents of the enclosed packet carefully and complete the enclosed forms prior to your appointment. If you still have questions please call us at 816-246-2131.

**ALLERGY TESTING:**

You are scheduled to have allergy skin testing done. This test will help determine what substances you may be allergic to. The basic test contains the most common substances causing allergies including tree, grass, and weed pollen, dust mites, cat and dog dander as well as mold to name a few. This test is comprised of a series of skin pricks on your back. You will have to lay flat on an exam table on your stomach for 15 minutes. Please wear a separate top that can be easily removed for this part of the test. After 15 minutes, the nurse will look at your back and grade the reactions. If you are allergic to a substance, it will look and feel like a mosquito bite. Depending on how large that "mosquito bite" is determines if you are allergic to that substance.

**INSTRUCTIONS:**

1. All antihistamines must be out of your system for this test to be accurate. Most have to be stopped 3 days prior to the appointment. Claritin needs to be stopped 7 days prior to the appointment. **If you are unsure if a medication you are taking is or contains an antihistamine, please ask us or your pharmacist.**
2. Medications for asthma do not need to be discontinued unless instructed by your physician.
3. Wear a separate top that can be easily removed, a sleeveless shirt (or under-shirt), and a button-up sweater if you tend to chill.
4. Plan on being in the office for approximately 1-2 hours. If you are around any "critters" that you would like to have included in your testing (ex. hamsters, horses), please inform the nurse before testing begins.

**Patricia E Jones, MD Allergy & Asthma Center, P.C.**

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**Please read the following information carefully.** The following is a *partial* list of medications that contain antihistamines. Many oral products for cold and allergy, as well as sleep aids, anti-nausea and antidepressant medication frequently contain antihistamines. Any product listed below should be stopped 72 hours before you are scheduled for skin testing unless otherwise noted. If you have any questions regarding whether a medication is an antihistamine, please contact us or your pharmacy.

- (1) **Discontinue only if okay with prescribing physician !!**  
(2) **Discontinue one week before evaluation !!**

Actifed	Contac	Nolamine	Surmontil
Alka-Seltzer Plus	Coricidin	<b>Nortipityline (1,2)</b>	Tamine
Allegra	Cyroheptadine	Novahistine	Tavist
Allegra-D	<b>Desipramine (1,2)</b>	Nyquil	Theraflu
Allerest	Dimetapp	Nytol	<b>Thorazine (1)</b>
AllerRx	Diphenhydramine	Ornade	<b>Tofranil (1,2)</b>
Alumadrine	Disophrol	Patanol Eye Drops	Triaminic
<b>Amitriptyline (1,2)</b>	Doan's P.M.	Pediacure	Trifluoperazine
Antivert	Dorcol Cold Formula	Periactin	Trilafon
Astelin Nasal Spray (2)	<b>Doxepin (1,2)</b>	Phenergan	Tripelennamine
Atrohist	Dramamine	Poly-Histine	Tussagasic
BC Cold Powder	Dristin	Prochlorperazine	Tussed
Bayer P.M.	Drixoral	<b>Prolixine (1)</b>	Tussi-12
Benadryl	Dura-Vent/DA	Robitussin Night	Tussionex
Bonine	Elavil (1,2)	Time Cold	Tylenol Allergy Sinus
Bromfed	4-Way Cold Tabs	Rondec	Tylenol Cold
Bufferin AF Nite	Histussin	Rynatan	Tylenol Cold & Flu
Children's Tylenol	Hycamine	Semprex D	Tylenol Cold Night
Allergy D	Hydroxyzine	<b>Sinequan (1,2)</b>	Tylenol PM
Children's Tylenol	<b>Imipramine (1,2)</b>	Sinutab	Unisom
Cold & Flu	<b>Limbitrol (1,2)</b>	Simply Sleep	Vicks
	Loratadine (2)		
Chlorpheniramine	Meclizine	Sominex	Vistaril
Chlor-Trimeton	Medi-Flu	St. Joseph Night	<b>Vivactil (1,2)</b>
Claritin (2)	<b>Mellaril (1,2)</b>	<b>Stelazine (1)</b>	Zyrtec
Claritin D (2)	Miles Nervine	Sudafed Cold & Allergy	Zyrtec D
Cold Control	Nighttime Sleep Aid		Viravan
Compazine	Naldecon		
Comtrex			

**Plan Sudafed may be taken**

**Singulair should be stopped 12 hours before testing.**

## Patient Payment Policy

*Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusions regarding payment for professional medical services. **Please sign below that you have read and agree to this policy.***

### Payment Policy

Payment for service is due in full at the time of service.

We accept cash, check, Visa and MasterCard.

All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.

If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above.

For elective or uncovered services, all co-payments and deductibles are due on the date of service. However, for services estimated to cost more than \$200, we will accept half of the balance as the minimum payment. Upon request, a short-term payment arrangement can be considered. **A \$5.00 monthly service charge will be assessed for accounts over 45 days.**

**If your account is over 120 days past due, it will be referred to a collection agency.** This is a last resort, done reluctantly, and after we have exhausted efforts for voluntary payment.

### Referrals

It is your responsibility to bring any required referral for treatment at, or prior to the time of, your visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible.

### Acknowledgement and Authorization

I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Printed Name

**PATIENT INFORMATION**

Patient Full Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouses Name \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Name of Physician referred by \_\_\_\_\_ / Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ / Phone # \_\_\_\_\_

In case of an emergency notify nearest relative not living with you \_\_\_\_\_

**INSURANCE CARRIER EMPLOYMENT INFORMATION**

Insurance Carrier \_\_\_\_\_ Member ID# \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Work Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ SSN \_\_\_\_\_

*Please let us know if the insurance has changed from your last visit to update our records. This ensures timely payment for your visit.*

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I hereby authorize Patricia E. Jones, M.D., Allergy & Asthma Center and it's physicians to treat me/my child. I authorize payment of my insurance benefits to be made to Patricia E. Jones, M.D., Allergy & Asthma Center for any services furnished to me by the physicians in that group. I understand that I am financially responsible for all charges whether paid by insurance or not. (This excludes patients covered by insurance companies with which we have a contract). Should my account become delinquent, I understand that I may be responsible for additional charges if this account is referred to an attorney. I understand that the privacy practices are posted in the office, and a copy is available to me if I request one. I also authorize Patricia E. Jones, M.D., Allergy & Asthma Center to release medical information to insurance companies in order for the insurance companies to determine payment for services rendered to me. This shall serve as a lifetime authorization.

**XXXX**

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SIGNATURE

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Referring Physician

\_\_\_\_\_  
Accompanied Today By

**In the boxes below – please mark all that apply.**

*Reason(s) for  
Visit*

- |  |   |
|--|---|
| <input type="checkbox"/> hay fever/nasal allergies | <input type="checkbox"/> ear problems               |
| <input type="checkbox"/> rash/skin allergies       | <input type="checkbox"/> drug reaction              |
| <input type="checkbox"/> food allergy              | <input type="checkbox"/> cough                      |
| <input type="checkbox"/> insect allergy            | <input type="checkbox"/> shortness of breath/asthma |
| <input type="checkbox"/> eye problems              | <input type="checkbox"/> chest infections           |
| <input type="checkbox"/> headache/sinus problems   | <input type="checkbox"/> Other: _____               |

**First time problems** \_\_\_\_\_ **When did this specific episode**  1 week ago  2 weeks ago  
**occured?** (date) **start?**  3 weeks ago  4 weeks ago  
 more than a month ago  
 unknown

**How often does this problem**  everyday  once per week  2 x per week  
**occur?**  monthly  several times a year  unpredictable

**Which month(s) is it most**  Jan  Feb  March  April  May  June  
**severe?**  July  Aug  Sept  Oct  Nov  Dec  All year

**What time of day are the**  morning  noon  afternoon  nighttime  all the time  
**symptoms worse?**

**Are symptoms worse in**  home  work  outside  indoors  other: \_\_\_\_\_  
**certain locations?**

**Suspected cause of**  trees  weeds  grass  mold  dust  perfumes  scents  latex  
**problems?**  weather changes  heat  cold  cats  dogs  stress  smoke  
 other (animals, foods, etc.): \_\_\_\_\_

**How would you grade the**  none  mild  moderate  severe  
**degree of your symptoms in the**  
**last 4 weeks?**

**How would grade your**  none  mild  moderate  severe  
**degree of symptoms today?**

## Review of Symptoms I

Please grade each of the following symptoms. **(Mark all that apply)**

	None	Mild	Moderate	Severe	
<i>Allergy/Sinus Symptoms</i>	Dark circles under eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy/watery eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Red Eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Swollen/puffy eyelids:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear infections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear pain/pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear popping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congestion/blocked nose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased sense of smell:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nasal/sinus drainage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nose bleeds:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Runny nose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus infection:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus pressure/pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sneezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snoring:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snorting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sore throat:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hoarseness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Post nasal/throat drainage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat clearing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Neurological Symptoms</i>	Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue/tired:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Headache:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lightheadedness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Problems sleeping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor concentration:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sleep apnea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Asthma Symptoms</i>	Croup/laryngitis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest infections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest tightness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cough:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cough productive of mucus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congestion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath(SOB):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SOB with exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SOB at night:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Skin Symptoms</i>	Dry skin:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy skin:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rash:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Skin Swelling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Mild	Moderate	Severe	
<i>Gastrointestinal Symptoms</i>	Constipation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diarrhea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heartburn/Indigestion/Reflux:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nausea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vomiting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Review of Symptoms II

**(Mark all that apply)**

<i>General:</i>	<input type="checkbox"/> fever	<input type="checkbox"/> chills	<input type="checkbox"/> night sweats	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain
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<i>Ears:</i>	<input type="checkbox"/> drainage	<input type="checkbox"/> hearing loss	<input type="checkbox"/> rupture of eardrum
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<i>Eyes:</i>	<input type="checkbox"/> burning	<input type="checkbox"/> dry
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<i>Mouth:</i>	<input type="checkbox"/> bad breath	<input type="checkbox"/> gum problems	<input type="checkbox"/> lip swelling	<input type="checkbox"/> tongue swelling	<input type="checkbox"/> pain in teeth
	<input type="checkbox"/> teeth grinding	<input type="checkbox"/> mouth itching	<input type="checkbox"/> mouth ulcers		

<i>Throat:</i>	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> swelling	<input type="checkbox"/> loss of voice
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<i>Chest:</i>	<input type="checkbox"/> chest pain	<input type="checkbox"/> heaviness/pressure	<input type="checkbox"/> heart palpitations
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<i>Urinary:</i>	<input type="checkbox"/> excessive urination	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> pain/burning with urination
	<input type="checkbox"/> difficulty with urination		

<i>Extremities:</i>	<input type="checkbox"/> swollen joints	<input type="checkbox"/> painful joints	<input type="checkbox"/> athletes foot/nail fungus
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<i>Neurological:</i>	<input type="checkbox"/> anxiety	<input type="checkbox"/> stress	<input type="checkbox"/> depression	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> tremors
	<input type="checkbox"/> developmental/growth delay	<input type="checkbox"/> heat or cold intolerance			

<i>Other:</i>	
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<i>Asthma History A.</i>	1. Have you been previously diagnosed with asthma? Yes No If No – go to Section B			
	2. What was your age when your asthma began? _____ years			
	3. During a typical week, how often do asthma attacks awaken you at night?	<input type="checkbox"/> less than once/week	<input type="checkbox"/> once or twice/week	<input type="checkbox"/> 3 x or more/week
		<input type="checkbox"/> more than once/night	<input type="checkbox"/> never	
	4. During a typical week (in the past 12 months) how often did you use a Beta Agonist (like Proventil, Albuterol or Ventolin) for asthma?	<input type="checkbox"/> less than once/week	<input type="checkbox"/> once or twice/week	<input type="checkbox"/> 3 x or more/week
		<input type="checkbox"/> daily	<input type="checkbox"/> more than once daily	<input type="checkbox"/> never
	5. During a typical week, how often were your activities limited by asthma symptoms such as cough, wheezing, or shortness of breath?	<input type="checkbox"/> less than once/week	<input type="checkbox"/> once/week	<input type="checkbox"/> 1 x or more/week
		<input type="checkbox"/> daily	<input type="checkbox"/> never	
	6. During the past 12 months, how many times have you gone to the emergency room or had an urgent doctor's visit because of asthma?	<input type="checkbox"/> none	<input type="checkbox"/> 1 x	<input type="checkbox"/> 2 x
		<input type="checkbox"/> 3 x or more		
	7. Have you been admitted overnight to a hospital for asthma or breathing disorder in the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	8. Do you get chest tightness, wheezing, or shortness of breath within the first 15 minutes of exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

9. Do you check peak flows?  Yes  No Best peak flow value \_\_\_\_\_

10. Do you have a written Asthma Action Plan?  Yes  No

**Please complete entire section.**

<i>Asthma History</i> B.	1. Did you ever have recurrent bronchitis, croup, asthma, reactive airway disease during childhood? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Have you had sudden severe episodes of coughing, wheezing or shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Have you had colds that go “to the chest” and take more than 10 days to get over? <input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Have you had coughing, wheezing, or shortness of breath in certain places when exposed to certain things (e.g. animals, tobacco, smoke, perfumes, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Have you used medicine to help your breathing? If yes, do symptoms get better with medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Do you have coughing, wheezing, or shortness of breath . . . in the morning? <input type="checkbox"/> Yes <input type="checkbox"/> No at night? <input type="checkbox"/> Yes <input type="checkbox"/> No with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other: _____

<i>Sinus History</i>	1. Do you have sinus problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If <u>No</u> – Go to Allergy History Section</b>
	2. How many times have you been treated for a sinus infection with an antibiotic in the past year? <input type="checkbox"/> none <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x or more Which antibiotic helped the most? _____
	3. What is the color of your nasal drainage? <b>(Mark all that apply)</b> <input type="checkbox"/> clear <input type="checkbox"/> brown <input type="checkbox"/> white <input type="checkbox"/> green <input type="checkbox"/> yellow <input type="checkbox"/> blood-tinged
	4. Have you ever had nasal polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Have you ever had an x-ray or CT scan of your sinuses? <input type="checkbox"/> Yes <input type="checkbox"/> No When was x-ray/scan done? _____ Where was x-ray/scan performed? _____
	6. Have you ever had sinus surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No When was the sinus surgery? _____ Who was the surgeon? _____ Did the surgery help? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
	7. Do the sinus problems disturb your sleep enough to cause fatigue, tiredness, or sleepiness during the day? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>General Other:</b> _____

<i>Allergy History</i>	1. Have you ever been tested for allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If <u>NO</u> – Go to question #2</b>
	How was testing performed? <input type="checkbox"/> skin <input type="checkbox"/> blood (rast)
	How long ago was the test? <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-3 years <input type="checkbox"/> 4 + years <input type="checkbox"/> don't remember
	What were you allergic to? <input type="checkbox"/> trees <input type="checkbox"/> weeds <input type="checkbox"/> grasses <input type="checkbox"/> mold <input type="checkbox"/> cats <input type="checkbox"/> dogs <input type="checkbox"/> foods <input type="checkbox"/> insects <input type="checkbox"/> latex
	Did you get allergy shots? <input type="checkbox"/> Yes <input type="checkbox"/> No
	How long did you take the shots? <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Weeks If yes, were the shots helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Who was your doctor? _____ Where can we obtain your allergy test results? _____ Any reaction to insects? <input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Allergy History Continued</i>	Insect Type <b>(Mark all that apply)</b> <input type="checkbox"/> wasp <input type="checkbox"/> honey bee <input type="checkbox"/> yellow jacket <input type="checkbox"/> white faced hornet <input type="checkbox"/> yellow hornet <input type="checkbox"/> fire ant <input type="checkbox"/> mosquito <input type="checkbox"/> not sure Type of reaction: _____
	2. Have you ever been prescribed an epi-pen (adrenalin/epinephrine)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____  Other: _____

<i>General History</i>	1. In the last 6 months, have you had a cough longer than 6 weeks in a row? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. In the last 6 months, have you had hoarseness for greater than 6 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. In the last 6 months, have you coughed up any blood or bloody sputum? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Have you had a chest x-ray in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, where was it performed? _____ When? _____  What were the results? _____
	5. Have you had the pneumonia vaccine shot (Pneumovax)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ 6. Do you normally get a flu shot every year? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Are your immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. During the last year, how many times have you had to take oral or injected steroids for allergies or asthma? <input type="checkbox"/> none <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x or more 9. During the last year, how many days have you missed school or work because of your allergies or asthma? <input type="checkbox"/> none <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x or more 10. During the last year, how many days have your allergies or asthma changed your productivity at work/school due to symptoms? <input type="checkbox"/> none <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x or more 11. How many times have you gone to the emergency room because of your allergies or asthma? <input type="checkbox"/> none <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x or more 12. How many times have you had to stay overnight at the hospital because of allergies or asthma? <input type="checkbox"/> none <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x or more 13. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last menstrual period? _____  Other: _____

<i>Social History</i>	1. Occupation _____ <input type="checkbox"/> n/a <input type="checkbox"/> student <input type="checkbox"/> retired  2. Type of work: _____  3. Hobbies: _____ 4. Personal tobacco use: <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> never How many years have you smoked? _____  How many packs per day? _____
	5. Second hand exposure to tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Who? _____ Where? _____ 6. Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Recreational drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Do you have any HIV risk factors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

**(Mark all that apply)**

<i><b>Environmental History</b></i>	1. Do you have any pets? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	Type of pets? <input type="checkbox"/> cats <span style="margin-left: 100px;">How many? _____</span> <input type="checkbox"/> dogs <span style="margin-left: 100px;">How many? _____</span> <input type="checkbox"/> other <span style="margin-left: 100px;">How many? _____</span>
	Are they . . . ? <input type="checkbox"/> inside <input type="checkbox"/> outside <input type="checkbox"/> both
	Do they sleep in the bedroom? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
	2. How old is your home/apartment? _____ years
3. Has there been any water leakage or water damage in your home? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
4. Do you have visible mold or a musty odor in your home? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
5. If patient is a child, does he/she attend daycare? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

<i><b>Family History</b></i>	What is your ethnic background? <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other																																																																																				
	Are there any family disputes/divorce situations that may make caring for patient more difficult? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>																																																																																				
	<b>(Mark any family members who have experienced any of the listed conditions)</b>																																																																																				
	<table border="1"> <thead> <tr> <th></th> <th>Father</th> <th>Mother</th> <th>Brothers</th> <th>Sisters</th> <th>Children</th> <th>Others</th> </tr> </thead> <tbody> <tr> <td>Allergies:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sinus:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Asthma:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Eczema:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hay fever:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hives:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Migraine:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Thyroid Disease:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Emphysema:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cystic Fibrosis:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Tuberculosis:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Father	Mother	Brothers	Sisters	Children	Others	Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other: _____																																																																																					

<i><b>Medical History</b></i>	<b>Please mark all that describe <u>your</u> current or past medical problems.</b>												
	<input type="checkbox"/> high blood pressure <span style="margin-left: 100px;"><input type="checkbox"/> reflux</span> <span style="margin-left: 100px;"><input type="checkbox"/> thyroid problems</span> <input type="checkbox"/> heart attack <span style="margin-left: 100px;"><input type="checkbox"/> hiatal hernia</span> <span style="margin-left: 100px;"><input type="checkbox"/> kidney problems</span> <input type="checkbox"/> stroke <span style="margin-left: 100px;"><input type="checkbox"/> diabetes</span> <span style="margin-left: 100px;"><input type="checkbox"/> chronic infections</span> <input type="checkbox"/> glaucoma <span style="margin-left: 100px;"><input type="checkbox"/> emphysema</span> <span style="margin-left: 100px;"><input type="checkbox"/> skin problems</span> <input type="checkbox"/> cataracts <span style="margin-left: 100px;"><input type="checkbox"/> lupus/other</span> <span style="margin-left: 100px;"><input type="checkbox"/> liver problems</span> <span style="margin-left: 100px;">autoimmune disease</span>												
	<input type="checkbox"/> depression <span style="margin-left: 100px;"><input type="checkbox"/> gout</span> <span style="margin-left: 100px;"><input type="checkbox"/> bleeding problems</span> <input type="checkbox"/> bipolar <span style="margin-left: 100px;"><input type="checkbox"/> arthritis</span> <span style="margin-left: 100px;"><input type="checkbox"/> osteoporosis/osteopenia</span> <input type="checkbox"/> ADD/ADHD <span style="margin-left: 100px;"><input type="checkbox"/> fibromyalgia</span>												
	<b>Please list all previous hospitalizations/surgeries/prosthetics devices (artificial limbs).</b>												
	<table border="1"> <thead> <tr> <th>Description</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Description	Year	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	Description	Year											
	_____	_____											
	_____	_____											
	_____	_____											
	_____	_____											
_____	_____												

**Please list your prescription, non-prescription, herbal drugs, creams, sprays, pills, liquids, drops, or inhalers.**

**Current Medications**

	<b>Medication Name</b>	<b>Dose</b>	<b>Frequency</b>
<i>Medication History</i>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you have any known drug allergies or intolerance to medications?  Yes  No

**Medication Allergies:**

	Medication Name	Type of Reaction	When/Date	
<i>Medication Or Food Allergies</i>	_____	_____	_____	
	_____	_____	_____	
	_____	_____	_____	
	_____	_____	_____	
	<b>Food Allergies:</b>			
		Food	Type of Reaction	When/Date
	_____	_____	_____	
	_____	_____	_____	

Other Notes: \_\_\_\_\_

<i>Pharmacy Information</i>	Pharmacy Name: _____	Phone Number		
	Pharmacy Address: _____	Street		
	_____	City		
	_____	State		
Prescription Type:	<input type="checkbox"/> 90 day mail in	<input type="checkbox"/> Local	<input type="checkbox"/> Mail & Local	Zip