ALLERGY & ASTHMA CENTER

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2445 Marietta Avenue
Lancaster, Pennsylvania 17601

Telephone (717)-393-1365
By Appointment Only

APPOINTMENT DATE: **TIME**:

APPOINTMENT OFFICE: **(map enclosed) PHONE**:

PHYSICIAN'S NAME:

Dear

PLEASE REVIEW THIS FORM AS SOON AS POSSIBLE

Welcome to our practice. We are dedicated to giving you the best quality care in the fields of allergy, asthma, and immunology. The following information will help you make the most of your time during your visit.

ABOUT YOUR VISIT

At your first consultation, your physician will review your allergy and/or asthma history and do an appropriate physical examination. You will be given the opportunity to discuss with your doctor your own concerns and questions related to allergy and asthma.

Your physician may order skin testing, which will be done during this first visit. Test findings will be discussed with you upon completion. There are often multiple tests; please allow a minimum of **three hours** for your first appointment. We also ask that you arrive **15 minutes early** to check in with our front desk staff.

****Note**: A parent/legal guardian must accompany patients under 18 years old and plan to stay for the entire first appointment. For future appointments, an adult other than a parent/legal guardian may accompany a minor child with a signed Consent to Treat form.

MEDICAL INFORMATION

1. Two forms are enclosed **to complete before your initial visit**. Please be sure to bring them with you.

   - **Medical History form**: Please complete as accurately as possible, including all questions in the personal allergy history section. List all medications you take, including dosage and frequency of use. **Bring the medication bottles with you**.

   - **Insurance Billing form**: Please complete the information necessary for our business office. **Bring your health insurance cards with you.**

2. We need any relevant reports from **laboratory studies, CT scans, or x-rays** (blood work, CTs of sinuses, chest x-rays, etc. – not the films, just the reports.) done in the past six months, if any. **Please obtain copies of the reports**, and either bring them with you, or have them faxed to your appointment office at: (717)_____.

ABOUT SKIN TESTING

Should your doctor decide to do skin testing on the day of your appointment, **it is important that you stop taking certain medications EARLY** that interfere with the test results**.** Although other drugs may interfere, antihistamines are the **ONLY** medicines you should discontinue without prior authorization from your family physician. **DO NOT STOP ANY MEDICATION TAKEN FOR ASTHMA.** Drugs (antihistamines) to be stopped early are listed below. Call if you are uncertain.

Stop the following drugs THREE (3) days before your appointment:

Advil PM
Alamay & Zaditor Drops
Astelin
Astepro
Deconamine
Diphenhydramine
Dymista
Elestat Ophthalmic Solution
Livostin Ophthalmic Solution
Optivar Ophthalmic Solution
Pataday
Patanol
Patanase
Periactic (cyproheptadine)
Rynatan
Trinalin or Optimine
Veramyst
All over-the-counter antihistamines, cold medicines, and allergy eye drops, **such as**: Benadryl, Dimetapp, Tavist products, Chlor-Trimeton, Actifed, Tylenol Allergy Sinus, Tylenol PM, Teldrin, PediaCare, Visine Allergy Relief, **etc.**
OTC medications to help you sleep

Stop the following drugs FIVE (5) days before your appointment:

Allegra/Fexofenadine Products
AlleRx
Alavert
Atarax
Clarinex
Claritin/Loratadine Products
Doxepin
Hydroxyzine
Promethazine
Phenergan
Vistaril
Xyzal/Levocetrizine
Zyrtec/Cetirizine Products
Meclizine**
Antivert**

**If you are unable to STOP these medications please contact our office to discuss your appointment.

All other medications should be continued unless otherwise advised.

FINANCIAL ARRANGEMENTS

1. Please bring your current medical **insurance card(s)** with you to the visit.
2. Be prepared to **pay your co-pay at the time of your visit**. We participate with most major insurance companies and will accept assignment.
3. If you are insured through an HMO plan**, it is your responsibility to obtain a referral** from your primary care physician before your visit. Either have your primary care physician fax it to us before your appointment, or bring the completed form with you.

YOUR APPOINTMENT – REMEMBER TO BRING:

- Completed Medical History form. Your doctor needs this information about you.
- Completed Insurance Billing form.
- Reports from any pertinent CT scans, chest x-rays, or laboratory studies done in the past six months
- Health insurance cards.
- Completed referral form from your primary care physician if you have HMO insurance.
- Co-pay.
- Your allergy and asthma questions for your doctor.

****Please Note**: In consideration for our patients who have allergic sensitivities to scented products, please do not wear perfume or cologne of any kind, scented hair sprays, etc. when visiting our office.

APPOINTMENT CANCELLATION POLICY

Many patients need our services. A last minute cancellation deprives someone else of an appointment time. Please notify our New Patient Coordinator of a cancellation or request for an appointment change at least 72 hours (three days) in advance of your appointment. **If we do not have notification of your cancellation within 48 hours of your appointment, either directly or by voice mail, there will be a $50.00 fee for your absence.**

QUESTIONS?

If you have any questions about your initial visit or any part of the preceding instructions, please feel free to call.

For additional information about the practice, our physicians, and current allergy and asthma topics, please visit our website at **www.allergydoctors.com**.

Sincerely,

New Patient Coordinator

ALLERGY & ASTHMA CENTER

Please complete this form and give to Receptionist along with insurance card.

TODAY'S DATE _____

PATIENT INFORMATION

PATIENT'S NAME _____ M ( ) F ( ) SSN: _____ DOB: _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. (___) _____ MARITAL STATUS:(circle)S M D W LANGUAGE _____ RACE _____

EMAIL: _____ ETHNICITY: (circle) HISPANIC OR LATINO, NONHISPANIC OR LATINO, OTHER

EMPLOYER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE NO. (_____) _____ EXT _____ OCCUPATION _____

NEW PATIENT _____ YES ____ NO (IF NAME CHANGED; FORMER NAME) _____

REFERRING PHYSICIAN: NAME: _____, _____
LAST FIRST

ADDRESS _____ PHONE NO._____

FAMILY PHYSICIAN: NAME: _____, _____ MI: _____
LAST FIRST

ADDRESS _____, CITY _____, ZIP _____

SPOUSE/PARENT/RESPONSIBLE PERSON'S INFORMATION

NAME _____ DOB: _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. (_____) _____ SOCIAL SECURITY NO: _____

EMPLOYER'S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. (_____) _____ EXT _____ OCCUPATION _____

INSURANCE INFORMATION

INSURANCE COMPANY (Primary)
NAME _____
INS. COMPANY ADDRESS _____
_____
ID # _____ GRP. PLAN _____
_____ _____
INSURED (if not patient) Date of Birth
_____
INSURER'S EMPLOYER
SOCIAL SECURITY # _____

INSURANCE COMPANY (Secondary)
NAME _____
INS. COMPANY ADDRESS _____
_____
ID # _____ GRP. PLAN
_____
_____ _____
INSURED (if not patient) Date of Birth
_____
INSURER'S EMPLOYER
SOCIAL SECURITY #
_____

AUTHORIZATIONS

1) STAEMENT OF FINANCIAL RESPONSIBILITY: I hereby agree to pay Allergy & Asthma Center for all charges (to include co-pays, deductibles) at time of service; however, I understand that Allergy & Asthma Center may accept assignment of insurance benefits in lieu of payment at time of service. I further understand that Allergy & Asthma Center will attempt to collect the assigned insurance benefits; however, the full amount will still be my responsibility.
2) AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Allergy and Asthma Center to release any information including information regarding my diagnosis and treatment by the insurance company necessary to collect benefits under the policies stated at the time of treatment.

SIGNATURE _____ _____ _____
Patient or Legal Guardian Relationship to Patient Date

Patient Name:_____ **Date:**_____
AAC#: _____ **Patient Signature:** _____

REVIEW OF SYSTEMS
Do you have any of the following? (ANSWER YES OR NO)
Please provide explanations next to the various items if you experience them. (Examples: when, how often, and how severe?)

General
____significant change in weight □ yes □ no
□ up □ down
____recent fevers or chills □ yes □ no

HEENT
___ Runny nose
___ Sneezing
___ Nasal itching
___ Eye itching
___ Nasal congestion

Skin
____skin rashes (if you are here primarily for an evaluation of a rash we will discuss this in detail)
____recurrent skin infections

Respiratory
____ Wheeze
____ Shortness of breath
____ Cough

Gastrointestinal
____acid taste or regurgitation of food
____bloating
____heartburn
____nausea
____vomiting
____ diarrhea

Cardiovascular
____ankle swelling
____chest pain
____palpitations

Urinary
____blood in the urine
____burning or pain with urination
____loss of urine with coughing
____trouble with urinary flow

Hematologic
____anemia
____bleeding
____bruising easily

Musculoskeletal
___ joint pain

Endocrine
____particularly intolerant to cold □ yes □ no
____particularly intolerant to heat □ yes □ no

Gynecological _____N/A
____abnormal vaginal discharge recently
____change in menstrual cycle
____excessive bleeding

Neurological
____tingling or numbness in an extremity
____unusual weakness-please describe

Psychological
_____excessive anxiety or worry
_____excessive sadness or depression

Patient Label

Name of Referring Doctor/Family Doctor: _____

MEMO TO NEW PATIENTS

AS A HELP TO OUR PROVIDERS, PLEASE WRITE A ONE TO THREE PARAGRAPH SUMMARY AS TO ONSET OF PROBLEM, MEDICATIONS USED, HOW HELPFUL EACH WAS, AND YOUR REMAINING SYMPTOMS.

ALLERGY & ASTHMA CENTER

New Patient Questionnaire

Date: _____

Patient's name: _____ Sex: ____ Age: _____ Birthdate: _____
Parent(s)' name(s) if patient is a minor: _____
Street: _____ City: _____ State: _____ Zip: _____
Home telephone: _____ Daytime telephone: _____ Cell Phone: _____
Parent's or responsible party's name: _____

Name of physician who sent you here: _____
Is there another doctor to whom a report should be sent? _____
Names of other family members seen in the practice: _____

I. PERSONAL ALLERGY HISTORY

Patient's MAIN complaint: _____

_____

When did the problem begin? _____

SYMPTOMS	Yes	No	?
Trouble with your nose?			
Nasal Itching			
Frequent sneezing			
Clear watery discharge			
White thick discharge			
Colored thick discharge			
Drainage down back of throat			
Periodic			
Constant			
Nasal congestion			
Periodic			
Constant			
Both sides			
One side			
Frequent throat-clearing			
Hoarseness/raspy voice			
Frequent sore throats			
Frequent pressure headaches			
Loss of sense of smell			
Loss of sense of taste			
Sinus infections			
Number per year _____			
Nasal polyps			
Frequent nose bleeds			
Snoring			
Do you use nasal sprays?			
What type? _____			
Trouble with your eyes?			
Redness			
Tearing/Watering			
Swelling			
Itching			
Burning			

SYMPTOMS	Yes	No	?
Trouble with your chest or breathing?			
Wheezing			
Shortness of breath			
Chest tightness			
Cough			
Symptoms noted with: Colds			
Exercise			
Animals			
Other _____			
If cough, describe: Loose			
Dry			
Constant			
Periodic			
Daytime			
Nighttime			
Colored mucus			
Have you seen a physician or been seen in an Emergency room for wheezing?			
Trouble with your skin?			
Rash			
Scaly patches			
Hives			
Swollen areas			
Poison ivy/oak			
Contact rash			
Trouble with your ears?			
Itching			
Popping			
Fluid in ears			
Infection/pain			
Decreased hearing			

What MEDICATIONS you have tried for your symptoms? Did they help? _____

_____

_____

Circle those things you think contribute to your symptoms or cause them to be WORSE:

Indoors	Weather Change	Hay	Candles
Outdoors	Temperature Change	Barns	Paint Fumes
At Home	Wet Weather	Raking Leaves	Perfumes
At School	Dry Weather	Damp Areas	Smoke
At Work	Cold Day	Dusty Environment	Cleaning products
Morning	Hot Day	Air Conditioning	Newspapers
Afternoon	Hot/Humid Day	Animals	While eating
At Nights	Windy Day	Air Pollution	After eating
Viral Infections	Mowing Lawn	Chemicals	Emotions

Certain drugs (describe): _____

Other: _____

II. MEDICAL HISTORY –

CIRCLE any conditions YOU HAVE (OR HAD IN THE PAST):

☐ **None**

Asthma	Migraine	Diabetes	Hepatitis
Hay Fever	Pneumonia	Kidney Disease	Tuberculosis
Eczema	Emphysema	Heart Disease	Arthritis
Bronchitis	Acid Reflux	High Blood Pressure	Cancer
Nasal Polyps			Other: _____

HOSPITALIZATIONS (list reason, date, and hospital) ☐ none

1) _____
2) _____
3) _____

LIST ALL MEDICATIONS you are now taking for ANY conditions. List dosages and how each is taken, or bring in your medications. ***Example***: Advair 250/50, one puff twice a day: _____

_____

_____

_____

Are you ALLERGIC to any MEDICATIONS? (Describe reaction): _____

_____

Are you ALLERGIC to INSECT STINGS? (Describe reaction): _____

_____

Are you ALLERGIC to any FOODS? (Describe reaction): _____

_____

III. FAMILY HISTORY

FAMILY MEMBER	AGE	DISEASES	WHICH RELATIVE(S)?
Mother		Sinus Problems	
Father		Hay Fever	
Siblings (name)		Nasal Allergies	
		Asthma	
		Emphysema	
		Nasal polyps	
Spouse		Cystic fibrosis	
Children (name)		High Blood Pressure	
		Heart Disease	
		Diabetes	
		Arthritis	
		Cancer	

IV. OCCUPATIONAL HISTORY (If patient is your child, state your occupation—it may be influencing your child's condition)

What is your occupation? _____ Employer: _____

Do you feel your occupation has anything to do with your symptoms? Explain: _____

_____

How long have you worked for your present employer? _____

IV. PERSONAL ENVIRONMENTAL HISTORY (Please check the correct answer or fill in the blank)

	YES	NO	?
HOME			
Type of home: House			
Apartment			
Dormitory			
Mobile home			
LOCATION			
City			
Apartment			
Town			
Within 100 yards of busy highway			
Suburb			
Country			
On a Farm			
Beside a Farm			
In the woods			
Next to water			
Busy Street			
HEATING			
Home heating: Forced air			
Radiant air			
Air filters change every 3 mo.?			
Kerosene Portable or Vented			
Gas			
Oil			
Coal			
Wood			
Air-Conditioned			
Window unit(s): # _____			
Central Air-Conditioned			
Humidifier			
Central			
Portable			
Portable next to heat source?			
Vaporizer			
Cool mist Vaporizer			
Steam Vaporizer			
Use: Constant use			
Occasionally used			
Used year-round			
Used when needed			
Do you use a portable air purifier?			
Purifier HEPA filter-type			
Purifier ionizer-type			
# of Air-Purifiers: _____			
Is home over 100 years old?			
Are there damp inside walls?			
Where?			
BASEMENT			
Do you have a basement			
Cement floor			
Dirt floor			
Used as living area			
Carpeted			
Painted Floor			
Rugs			

	YES	NO	?
Linoleum Floor			
Laminated Floor			
Tiled Floor			
Spring in Basement			
Entertainment			
Office			
Bedroom			
Storage			
DEHUMIDIFIER			
Type of Dehumidifier: Stand alone, self-emptied, hand emptied, Other:_____			
Central vacuum cleaner system			
Vented inside			
Vented outside			
BEDROOM			
Bedroom has wall-to-wall carpeting			
Bedroom has thrown rugs			
Partial carpeting			
Bedroom has no carpeting			
Bedroom in basement			
Bedroom on cement slab			
Bedroom on ground			
Does patient sleep with a pillow?			
Buckwheat Filled			
Synthetic Filled			
Feather/Down filled			
Not Known			
Pillow covered in dust mite proof cover			
Mattress covered in dust mite proof cover			
Fragrances used at home and how often:			
Circle: Weekly; Monthly; Daily			
Central vacuum cleaner system			
PETS			
Do you have animals in your home?			
Dog: # ( )			
Cat: # ( )			
Rabbit: # ( )			
Rodent: # ( )			
Ferret: # ( )			
Gerbil: # ( )			
Hamster: # ( )			
Guinea pig: # ( )			
Frog: # ( )			
Snakes: # ( )			
Bird # ( ) Type of bird:			
Have you had pets longer than 3 months			
Pets sleep in the bedroom			
Patient/family member participates in the care of pets (type)			
SMOKING			
Does patient smoke?			
Type: _____ Years: ___Start___ Quit:			
SMOKING			
Does patient smoke?			

Patient around smoke at:	
Home	
Daycare/preschool	
Babysitter	
Relative or friend	

Please circle the months of the year your symptoms are at their worst:

January	February	March	April
May	June	July	August
September	October	November	December

Are your symptoms year-round but worse during these months? Yes / No

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