AllergyCorp Group

New Patient Forms

Dear Patient,

Welcome to AllergyCorp Group Clinics. We are pleased you have chosen our clinic for your allergy, sinus, nasal, asthma, smell and taste disorders care.

Please take a moment to read the important information below.

Please arrive 15 minutes before your scheduled appointment time so that we can enter your information in our medical management computer system.

Please note that due to the nature of our practice, you may be at our office for up to 3 hours during your initial evaluation. Please schedule other obligations accordingly.

The items below are required during your first visit:

□ All enclosed forms completed.

□ Insurance referral if required

□ Insurance card(s) and any other information that will assist in filing insurance for you.

□ Photo identification

□ Medical records of past evaluations and treatments that may relate to your problems.

□ Any appropriate laboratory and radiological records, x-rays, and MRI/CT scan reports . Additional lab work may be necessary at the time of your visit. Please make sure that you are fully hydrated 24 hrs prior to your appointment, as this will ensure a more successful blood draw.

□ Names, addresses and phone numbers of other professionals with whom we should be communicating.

□ ALL medications that you are currently taking, including over-the-counter and herbal.

□ For a planned procedure(s), your doctor will give you specific instructions for preparing for the procedure. These will depend on your condition, current state of health and any medications you are taking. It may require a second office visit to perform the procedure.

□ Since your office appointment may take up to 3 hours, bringing some drinks and snacks can be beneficial for your comfort. The cliniuc will be closed for lunch between 1pm through 2pm. There is good number of restaurants (including fast food) near the clinic. If you would need hotel arrangements, our staff can recommend hotels near the clinic.

INSURANCE

Please be sure to identify your insurance plan when scheduling your appointment.
Any pre-authorizations required by your insurance are your responsibility.

We are pleased to participate in many insurance plans. As a courtesy, our insurance department will file your insurance claim for you. In order to provide this service, we will need a copy of your insurance card and a signed authorization form.

APPOINTMENT CONFIRMATION

If you are unable to attend your scheduled appointment, please notify the office at least 48 hours in advance. Failure to do so will result in cancellation fee of $75 for new patient appointments and $35 for established patient.

AllergyCorp Group

PATIENT REGISTRATION

1. PATIENT INFORMATION

Name_____ Birth date_____ Soc Sec#_____

Address _____ City/State_____ Zip_____

Home Phone_____ Work Phone _____ Cell Phone _____

Marital Status S / M / W / D Student FT / PT Male / Female Occupation _____

Other family members at our office? Y / N List names _____

Primary care physician _____ Were you referred to our office? YES / NO

If yes, referred by: ☐ Dr. _____ ☐ Patient_____ ☐ My insurance company

☐Newspaper Ad ☐ Google/Internet ☐ TV Ad ☐ Radio Ad ☐ Website banner Ad ☐ Billboard ☐ Other

EMAIL ADDRESS _____Would you like to receive email from us? Y / N

2. RESPONSIBLE PARTY

Name_____ Birth date_____ Soc Sec#_____

Address _____ City/State_____ Zip_____

Home Phone_____ Work Phone _____ Cell Phone _____

3. PRIMARY INSURANCE/POLICY HOLDER INFORMATION

Name_____ Birth date_____ Soc Sec#_____

Address _____ City/State_____ Zip_____

Name of Ins._____ ID No. _____ Group No. _____

4. SECONDARY INSURANCE/POLICY HOLDER INFORMATION

Name_____ Birth date_____ Soc Sec#_____

Address _____ City/State_____ Zip_____

Name of Ins._____ ID No. _____ Group No. _____

5. RECEIPT OF NOTICE PRIVACY PRACTICES WRITTEN ACKNOLEDGEMENT

I, _____, have read a copy of AllergyCorp Group notice of Privacy Practices.

6. AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization be used in place of original. I hereby authorize AllergyCorp Group to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made to AllergyCorp Group.
I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any payments sent to me by my insurance company will be forwarded to AllergyCorp Group to be applied toward my account should a balance exist.

Signature_____ **Date**_____
(Please type your name - Electronic Signature)

AllergyCorp Group

Financial Policy

The following information is to familiarize you with our billing policies:

- The AllergyCorp Group specialty clinics will bill your in or out of network insurance company for office visits. Any co-pays and/or deductibles will be due at the time of service.. Although eligibility has been checked with your insurance company prior to your office visit, this is NOT a guarantee of payment. **Benefits** are determined by your insurance company once the claim has been received and reviewed.

- If your insurance company was billed and payment is not received within 45 days, the balance will be transferred to the patient's responsibility. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Any portion of the bill not paid, or denied, by the insurance carrier, will be the patient's responsibility.

- If you have Medicare and a supplemental or secondary insurance carrier, please call Medicare and advise them of your secondary or supplemental information for the coordination of benefits. Medicare will coordinate claims with your secondary insurance carrier.

- Upon receipt of payment from your insurance company, you will receive a statement showing your balance due. Payment is expected within fourteen (14) days. For your convenience, we accept Visa, MasterCard, Discover, and American Express.

- If payment, IN FULL, is not received, you may be charged a $15 re-billing fee each time we issue you a statement on an outstanding balance over 30 days.

- If your bill is not paid and is transferred to our professional collection agency, then your information, which may include, but is not limited to, your name, address, phone number, social security number, employment and employment phone number, will be provided to them. You will be charged an additional 25% of your outstanding balance as well as any related court costs and attorney fees.

- If your insurance company requests a claim form, fill out your portion of the form and attach a copy of your itemized statement provided by our office. A physician's signature ***is not*** required. It is not necessary for our office to fill out the "Attending Physicians" portion of the claim. The statement is authentication in itself.

- You must inform our office if you have a new insurance carrier or if the insurance carrier has a new claim address. Please send us a copy of the front and back of your new insurance card so we can update our records. Failure to do so may result in

delayed claims and/or responsibility for unpaid claims.

- If you are unable to attend your scheduled appointment, please notify the office at least 48 hours in advance. Failure to do so will result in a cancellation fee of $75 for new patient appointments and $45 for established patient appointments.

- Please note: This office reserves the right to change its fees at any time without prior notice.

_____

Patient Name (please print)

_____ _____

Patient Signature (Please type your name-Electronic Signature) Date

AllergyCorp Group

Office Policies

We look forward to your visit to the AllergyuCorp Group specialty clinics. In order that our staff and physicians can provide you with prompt service, we ask that you do the following:

Please bring your medical insurance card(s) with you. We must make a copy of the card(s) for our records. Many medical insurance plans place limitations on which physicians or medical facilities their enrollees may use and still be covered. We encourage you to contact your primary care physician or your insurance company to familiarize yourself with the benefits of your medical insurance plan. Failure to obtain a referral could result in non-coverage by your insurance company; therefore, you could be held responsible for any charges resulting from this visit. If you belong to a managed care program, you must get referral(s) from your primary care physician.

The initial visit includes a history and physical examination. Battery of tests is usually required and usually include allergy testing (prick, intradermal, blood), pulmonary functional testing, airway inflamation and other laboratory testing.Depending on the outcome, you may be advised that further evaluations is indicated, such as nasal endoscopy, radiological examination (CT and/or MRI) of the head and sinuses. If any of theses tests have been done within the 6-months, or you have undergone a CT or MRI of the head or neck, please bring the reports with you, as the tests may not have to be repeated. Other tests may be required, and would be at an additional charge.

The costs of the initial visit vary from patient to patient, depending upon the specific problem and the procedures or tests involved. For more information regarding the cost of services, contact our office and ask for the patient coordinator.

Full payment is expected before the time of service, unless you have Medicare or a commercial insurance that is contracted and in network with our practice. As a courtesy to all patients, we will assist you in billing your insurance for your office visits, provided you submit a current copy of your insurance card. We ask that you pre-pay up to the outstanding deductible and any applicable copay and/or coinsurance. Any services not covered or denied by your insurance company will be your responsibility. If you are a member of an HMO, EPO, or POS in which the AllergyCorp Group specialty clinics participates, you must also bring a copy of your primary care physician referral. If you are not sure of the type of plan that you have, please contact the customer service of your insurance plan to determine whether you will need a referral to the Smell and Taste Clinic in order to receive benefits.

If you are unable to attend your scheduled appointment, please notify the office at least 48 hours in advance. Failure to do so will result in cancellation fee of $75 for new patient appointments and $35 for established patient appointments.

Advance Beneficiary Notice
Diagnostic Procedures

It is the goal of the Physicians at the AllergyCorp Group specialty clinics to offer you the best treatment plan based on the most accurate diagnosis. To obtain this diagnosis, our doctors may or recommend procedures tests to be performed during your visit.

These procedures may include, but are not limited to:

- Nasal Endoscopy / Laryngoscopy – an in- office surgical procedures using a sterile small camera to examine the nasal cavity and the larynx (throat).
- Allergy Testing – prick and intradermal skin testing, patch skin testing and blood (in viro) testing
- Respiratory Tests - that include pulmonary functioning testing, airway inflamation and other laboratory testing.

Depending on your insurance company's rules and regulations, you may be financially responsible for some or all of the cost of these procedures.

☐ I understand that my co-pay is for a routine office visit. Additional diagnostic procedures and tests are not included in a routine office visit and will result in additional charges. I will assume financial responsibility for charges that may be billed to me as a result of any diagnostic procedures / tests performed. Depending on my specific benefit plan the procedure / test charges may be applied to an annual deductible or co-insurance.

OR

☐ I do not authorize any procedures / tests to be performed during this visit, and by doing so, I understand that this may limit the information the doctor has available to determine the diagnosis and subsequent treatment.

_____ _____
Printed Name of Patient Date

_____
Patient's / Legal Guardian's Signature (Please type your name - Electronic Signature)

AllergyCorp Group

Acknowledgement of Receipt of Notice of Privacy Practices

Patients Name: ----------

Date of Birth: ----------

Chart#: ----------

I understand and have been provided with a copy of the Notice of Privacy Practices for AllergyCorp Group specialty clinics.

Patient/Legal Guardian/POA (please attach documents) Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- o An emergency existed & a signature was not possible at the time.
- o The individual refused to sign.
- o A copy was mailed with a request for a signature by return mail. o

  Unable to communicate with the patient for the following reason:

  _____

- o Other: _____

Prepared By: ----------

Signature: _____ Date: _____

Relationship to Patient: _____

Revised January 1, 2016 Staff Initials: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

OCCUPATION: _____

CURRENT DATE: _____

ALLERGY CLINIC

1. Name of person filling out this form: _____ Relationship to patient: _____

2. How did you find out about AllergyCorp Group Clinic or who suggested you visit us?

_____

3. Who is your Primary Care Physician? _____

4. Is there any other provider who should receive a copy of our report? _____

5. What is the reason you were referred to us today? (asthma, hay fever, nasal allergies, sinus, food, stomach problems, skin problems, bee, medication allergy, etc.)

6. What specific problems or symptoms are you having? (sneezing, cough, etc.)

_____

Please answer YES or NO if you have had any of the following within the past year or more:

NOSE
no problems Y☐ N☐
stuffy/congested Y☐ N☐
itchy Y☐ N☐
runny Y☐ N☐
discolored mucus Y☐ N☐
sneezing Y☐ N☐
post-nasal drip Y☐ N☐
nose rubbing Y☐ N☐
nosebleeds Y☐ N☐
polyps Y☐ N☐
no smell or taste Y☐ N☐

SINUSES
no problems Y☐ N☐
headaches Y☐ N☐
fullness/pressure/pain Y☐ N☐
recurrent sinusitis Y☐ N☐
recurrent head colds Y☐ N☐

CHEST
no problems Y☐ N☐
coughing Y☐ N☐
wheezing Y☐ N☐
tightness/pressure Y☐ N☐
short of breath Y☐ N☐
bronchitis Y☐ N☐
pneumonia Y☐ N☐
coughed up blood Y☐ N☐
coughed up sputum Y☐ N☐
trouble keeping up with peers when exercising Y☐ N☐
a.m. cough/wheeze Y☐ N☐
cough with exercise Y☐ N☐
ER visit for asthma Y☐ N☐
hospitalization for asthma/pneumonia Y☐ N☐

EYES
no problems Y☐ N☐
itchy Y☐ N☐
redness Y☐ N☐
watering/tearing Y☐ N☐
discharge Y☐ N☐
dryness Y☐ N☐
blurred vision Y☐ N☐
glaucoma Y☐ N☐
wear soft contacts Y☐ N☐

EARS
no problems Y☐ N☐
pain Y☐ N☐
pressure Y☐ N☐
popping Y☐ N☐
itchy Y☐ N☐
ringing Y☐ N☐
infections Y☐ N☐
hearing problems Y☐ N☐

GASTROINTESTINAL
no problems Y☐ N☐
gas Y☐ N☐
cramps/pain Y☐ N☐
bloating Y☐ N☐
diarrhea Y☐ N☐
vomiting Y☐ N☐
heartburn Y☐ N☐
reflux Y☐ N☐
IBS Y☐ N☐
trouble swallowing Y☐ N☐
food intolerance Y☐ N☐
hepatitis Y☐ N☐

THROAT & MOUTH
no problems Y☐ N☐
itchy Y☐ N☐
swelling Y☐ N☐
sore throat Y☐ N☐
post-nasal drip Y☐ N☐
drainage Y☐ N☐
throat clearing Y☐ N☐
hoarseness Y☐ N☐
bad breath Y☐ N☐
canker sores Y☐ N☐

SKIN
no problems Y☐ N☐
rash Y☐ N☐
hives/welts Y☐ N☐
swelling Y☐ N☐
itching Y☐ N☐
eczema Y☐ N☐
dryness Y☐ N☐

CONSTITUTIONAL
no problems Y☐ N☐
headaches Y☐ N☐
irritability Y☐ N☐
aggressive behavior Y☐ N☐
poor sleeping Y☐ N☐
fatigue Y☐ N☐
snoring Y☐ N☐
cold/heat intolerance Y☐ N☐
dizziness Y☐ N☐
vertigo Y☐ N☐
fever Y☐ N☐
weight changes Y☐ N☐
night sweats Y☐ N☐
growth delay Y☐ N☐
altered school/work performance Y☐ N☐
loss of balance Y☐ N☐

Which of the above are of greatest concern to you and impact most on your quality of life?

_____

PATIENT NAME: _____

7. Please provide us with some details of the history of your problem.

   Approximate date symptoms started._____ how long have they been occurring? _____
   Do they affect School/Work____Sports?____Pastimes?____Are they getting worse?____
   Did you have any other allergies before this?____

8. Have you noticed a pattern with your symptoms? ____

   What makes your symptoms worse? _____
   What makes your symptoms better? _____
   Is it worse in a particular month or season? _____

Are your symptoms affected by:

dust Y☐ N☐	leaf raking Y☐ N☐	poor air quality Y☐ N☐
treesY☐ N☐	exercise Y☐ N☐	viruses Y☐ N☐
grassY☐ N☐	stress Y☐ N☐	respiratory infections Y☐ N☐
weeds Y☐ N☐	laughter Y☐ N☐	newsprint Y☐ N☐
mold/mildew Y☐ N☐	heat/cold Y☐ N☐	fall Y☐ N☐
cats Y☐ N☐	wind Y☐ N☐	winter Y☐ N☐
dogs Y☐ N☐	weather changes Y☐ N☐	spring Y☐ N☐
other animals Y☐ N☐	fumes/chemical odors Y☐ N☐	summerY☐ N☐
feathers Y☐ N☐	soaps/detergents Y☐ N☐	

(see question #15 for foods, bee stings, latex)

9. What has provided the most relief (avoidance, specific medicines, allergy shots…)?

10. What has not helped?

11. If you have undergone prior allergy evaluation, please list physician, approximate date, and any known details regarding test results and treatment.

    Have you had a chest x-ray or sinus CT scan within the past 3 years? Y☐ N☐ If so, where? _____

12. Describe your smoking history:

    never ☐ Highest number of packs/day over the years _____
    former Y☐ N☐ Numbers of years you have smoked _____
    current Y☐ N☐ If applicable, how many years ago did you stop? _____

13. Please list all current medications, both prescription and over the counter and also list all herbal and/or nutritional products (also list when each was started):

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PATIENT NAME: _____

14. Please list all known medication allergies and intolerances. Describe the nature of reaction or side effect for each drug and approximate date or age at which the problem surfaced.

15. Please list all known suspected allergies or intolerances to foods, food additives and colorants, stinging insect venom and latex (natural rubber) products. Describe the nature of the reaction and approximate date or age at which the problem surfaced.

16. Have you had contact allergies to poison ivy, adhesives, metals, cosmetics, etc.? Describe.

17. If not yet covered above, have you had any of the following:

asthma Y☐ N☐	recurrent infections Y☐ N☐	sinus surgery Y☐ N☐
nasal allergies Y☐ N☐	recurrent ear infections Y☐ N☐	pneumonia Y☐ N☐
eczema Y☐ N☐	ear tubes Y☐ N☐	recurrent bronchitis Y☐ N☐
recurrent hives Y☐ N☐	adenoidectomy Y☐ N☐	meningitis Y☐ N☐
recurrent swelling Y☐ N☐	tonsillectomy Y☐ N☐	abscesses Y☐ N☐

18. Please describe your routine for regular exercise:

_____

Do you exercise regularly outdoors within 500 yards of a major roadway? Y☐ N☐

19. Home Environment: Age of home _____ rent ☐ own ☐

Levels of home _____ Basement? ☐ Crawl Space? ☐ Concrete Slab? ☐

Number of indoor cats _____ For how long? _____ Sleep in bed? Y☐ N☐

Number of indoor dogs _____ For how long? _____ Sleep in bed? Y☐ N☐

Other furred pets in home or outdoors? _____ For how long? _____

If cats or dogs were present only in past, how long has it been since such pets were in the home? _____

What type of animal(s)? _____

Number of smokers in the home? _____

Relationship of smoker(s) to patient _____

Central Air Conditioning in home? Y☐ N☐

If you have central AC, do you routinely open windows seasonally, temperature permitting? Y☐ N☐

Please check type of heat in home: Radiator☐ Forced Air☐ Electric/Heat Pump☐ Gas☐ Oil☐
Wood Stove☐ Propane☐ Floor Furnace☐

Your Bedroom:

Wall to wall carpet Y☐ N☐ Hardwood or Tile Y☐ N☐ Area Rugs Y☐ N☐

Washable throw rugs Y☐ N☐

Are pillows covered in special allergen-proofed encasings? Y☐ N☐

Is top mattress similarly encased? Y☐ N☐ (n/a if waterbed)

Is box spring encased? Y☐ N☐ Is comforter encased? Y☐ N☐

PATIENT NAME: _____

Is patient in a daycare setting? Y☐ N☐ If so, how many other children in attendance? _____
Pets in daycare? _____ Smokers? Y☐ N☐

Other exposure to pets outside the home? (friends, neighbors, relatives)

_____

If you live much of the year in a college dorm or apartment, please comment on that setting with the above issues in mind:

Are there any particular concerns regarding either the home or work setting not addressed above? (e.g. mouse or cockroach infestations, water damage, mold growth, leaky roof, poor ventilation, etc.) Please elaborate:

20. Review of Systems: (Have you had any of the following within the past year?)

Heart
no problems Y☐ N☐
high blood pressure Y☐ N☐
irregular beats Y☐ N☐
murmur Y☐ N☐
heart attack Y☐ N☐
surgery Y☐ N☐
ankle swelling Y☐ N☐
angina/chest pain Y☐ N☐
shortness of breath:
when walking Y☐ N☐
when lying down Y☐ N☐
climbing stairs Y☐ N☐
walking several blocks Y☐ N☐

Endocrine
no problems Y☐ N☐
diabetes Y☐ N☐
thyroid problems Y☐ N☐
brittle nails Y☐ N☐
change in hair texture Y☐ N☐
change in skin texture Y☐ N☐
premature puberty Y☐ N☐
delayed puberty Y☐ N☐

Musculoskeletal
no problems Y☐ N☐
muscle aches Y☐ N☐
joint pain Y☐ N☐
arthritis Y☐ N☐
fibromyalgia Y☐ N☐
osteoporosis Y☐ N☐
backaches Y☐ N☐
muscle spasms Y☐ N☐
joint redness Y☐ N☐
joint swelling Y☐ N☐
joint heat Y☐ N☐

Blood/Lymphatic
no problems Y☐ N☐
anemia Y☐ N☐
easy bruising Y☐ N☐
easy bleeding Y☐ N☐
swollen glands Y☐ N☐
blood clots Y☐ N☐
tired without reason Y☐ N☐

Genitourinary
no problems Y☐ N☐
bedwetting Y☐ N☐
frequent urination Y☐ N☐
urgent urination Y☐ N☐
difficult urination Y☐ N☐
yeast infection
on antibiotics Y☐ N☐
accidental urination
with cough Y☐ N☐

Neuropsychiatric
no problems Y☐ N☐
migraine Y☐ N☐
seizures Y☐ N☐
unconscious spells Y☐ N☐
tingling/weakness
in hands/feet Y☐ N☐
trembling of extremity Y☐ N☐
difficulty concentrating Y☐ N☐
impulsive behavior Y☐ N☐
chronic anxiety Y☐ N☐
memory difficulty Y☐ N☐
stress Y☐ N☐
depression Y☐ N☐
irritabilty Y☐ N☐
mood swings Y☐ N☐
difficulty interacting Y☐ N☐
drug/alcohol problems Y☐ N☐

Lungs
pneumonia Y☐ N☐
pleurisy Y☐ N☐
collapsed lung Y☐ N☐
bronchitis Y☐ N☐
last TB test _____
Positive ☐ Negative☐

Liver
hepatitis Y☐ N☐
cirrhosis Y☐ N☐

Other symptoms not listed above:

21. Past Medical History: (Have you had any of the following at any time in the past?)

Bee Sting Allergy Y☐ N☐
Allergy (Hayfever) Y☐ N☐
Food Allergy Y☐ N☐
Immune Problems Y☐ N☐
Tuberculosis Y☐ N☐
Postive TB Test Y☐ N☐
Migraine Y☐ N☐
Diabetes Y☐ N☐
Cataracts Y☐ N☐
Glaucoma Y☐ N☐
GERD Y☐ N☐
Stroke Y☐ N☐

Hiatal Hernia Y☐ N☐
Ulcers Y☐ N☐
Irritable Bowel Y☐ N☐
Crohn's Disease Y☐ N☐
Lactose Intolerance Y☐ N☐
Hepatitis Y☐ N☐
Arthritis Y☐ N☐
Cancer Y☐ N☐
Osteoporosis Y☐ N☐
ADD/ADHD Y☐ N☐
Thyroid Disease Y☐ N☐
(Graves, Hashimotos, thyroiditis, tumor, hyperthyroidism, hypothyroidism)

Abnormal Bone Density Y☐ N☐
Epilepsy/Seizures Y☐ N☐
Congenital Defects Y☐ N☐
Congestive Heart Disease Y☐ N☐
Heart Attack Y☐ N☐
Angioplasty Y☐ N☐
Bypass Surgery Y☐ N☐
Abnormal Stress Test Y☐ N☐
Drug Addiction Y☐ N☐
Alcoholism Y☐ N☐

PATIENT NAME: _____

For Children Specifically:

Full Term Y☐ N☐ If no, how many weeks? _____
Birth Complications Y☐ N☐ ADD Y☐ N☐ Learning Disability Y☐ N☐
Feeding Problems Y☐ N☐ ADHD Y☐ N☐ Growth Delay Y☐ N☐
Adverse Reactions Developmental Delay Y☐ N☐
to Vaccines Y☐ N☐

Other medical problems not listed above:

_____

List any surgeries with approximate dates:

_____

22. Family History:

	Good Health	Asthma	Hayfever	Eczema	Food Allergy	Living?	Other Diseases
Mother	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Father	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Siblings (any)	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐
Offspring	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐	Y☐ N☐

Family history of cystic fibrosis? Y☐ N☐ Family history of glaucoma? Y☐ N☐
Family history of immune deficiency Y☐ N☐ Family history of thyroid disease? Y☐ N☐

23. Immunization History:

Have you had Chicken Pox? Y☐ N☐ or did you get vaccinated for it? Y☐ N☐
Are other childhood immunizations up to date? Y☐ N☐
Do you routinely receive a flu shot each year? Y☐ N☐
When was your last TB skin test? _____ Unknown☐

24. Social History:

Marital Status: M☐ S☐ D☐ W☐
Hobbies: _____
If in college, where and what primary field of study? _____
Your estimated alcohol consumption? _____
Who lives in your home? _____
If you are a minor: Are parents married and living together? Y☐ N☐
If not, are parents separated, divorced, or is a parent deceased? _____
Do you divide time between homes? Y☐ N☐
Explain: _____
Does only one parent have legal custody? Y☐ N☐
Explain: _____

Any further comments?

_____ _____
Signature of person completing form Date

M.D., P.A. REVIEW: _____

SPECIAL INSTRUCTIONS

All antihistamines and certain cough suppressants and antidepressants must be stopped for designated periods of time before testing. See our website for more information. Check with the office if you have any doubt whether you may continue to take any given medication. Patients evaluated for HIVES and swelling should NOT discontinue medication. Please wear short sleeves. Please bring copies of any chest x-rays & sinus CT scans with you. Please do not mail forms, bring them with you. Thank you.

SINO-NASAL OUTCOME TEST (SNOT-20)

○ No Sinus-Nasal Problems

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be	5 Most Important Items
1. Need to blow nose	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
2. Sneezing	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
3. Runny nose	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
4. Cough	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
5. Post-nasal discharge	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
6. Thick nasal discharge	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
7. Ear fullness	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
8. Dizziness	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
9. Ear pain	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
10. Facial pain/pressure	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
11. Difficulty falling asleep	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
12. Wake up at night	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
13. Lack of a good night's sleep	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
14. Wake up tired	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
15. Fatigue	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
16. Reduced productivity	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
17. Reduced concentration	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
18. Frustrated/restless/irritable	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
19. Sad	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○
20. Embarrassed	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	○

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

Asthma Screening Questionnaire

○ No Asthma Problems

Questionnaire	Score
1. Do you cough more than the average person?	2 ☐
2. Do you have a cough that comes mainly from your chest and NOT from your throat?	2 ☐
3. Do you have worsening of the following symptoms when you lie down to sleep?	
Cough	1 ☐
Chest tightness	1 ☐
Wheeze	1 ☐
Shortness of breath	1 ☐
4. Do you have worsening of the following symptoms after exercise or physical activity?	
Cough	1 ☐
Chest tightness	1 ☐
Wheeze	1 ☐
Shortness of breath	1 ☐
5. Do you have worsening of the following symptoms after laughing or crying?	
Cough	1 ☐
Chest tightness	1 ☐
Wheeze	1 ☐
Shortness of breath	1 ☐
6. Do you have worsening of the following symptoms after talking on the phone?	
Cough	1 ☐
Chest tightness	1 ☐
Wheeze	1 ☐
Shortness of breath	1 ☐

URTICARIA (HIVES) QUESTIONNAIRE

☐ No Urticaria (Hives) Problem

Date this episode of hives first started: _____
How did it start? _____
Did you have hives prior to this episode? _____
If so when?_____
How long did it last?_____
How was it treated?_____
How often do you break out?

- ❑ Daily
- ❑ 3-5 times a week
- ❑ Weekly

How long does each individual hive last?

- ❑ Few hours
- ❑ A day
- ❑ Few days

Hives are:

- ❑ Itchy
- ❑ Painful

Hives are brought on by the following physical stimulation:

- ❑ Cold
- ❑ Exercise
- ❑ Heat
- ❑ Pressure (tight clothing)
- ❑ Scratching skin

Hives are brought on by the following foods:

- ❑ Dried fruits
- ❑ Beer, wine
- ❑ Avocado
- ❑ Banana
- ❑ Any pitted fruit (peach, plum, cherry, nectarine)
- ❑ Other: List_____

Hives are brought on by the following medications:

- ❑ Aspirin
- ❑ Ibuprofen (Advil, Motrin)
- ❑ Penicillin (Amoxicillin, Augmentin)
- ❑ Other: List_____

Associated conditions with hives (skin):

- ❑ Swelling of eyes, lips or other parts of body
- ❑ Joint pain
- ❑ Joint swelling (not just hives over the joints)

Associated conditions with hives (respiratory)

- ❑ Sneezing, itchy, runny nose
- ❑ Hoarseness
- ❑ Coughing
- ❑ Wheezing

Associated conditions with hives (gastrointestinal)

- ❑ Itchy mouth
- ❑ Swollen tongue
- ❑ Difficulty swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal pain
- ❑ Diarrhea

List any infections in the 2 months prior to the onset of hives:_____
_____

List any medications taken in the past month: _____
_____
_____

Family members with hives lasting for more than 2 months:

- ❑ Yes
- ❑ No

Screening Questionnaire for Smell and Taste Dysfunction

☐ **No Smell or Taste Problem**

1. Describe your sense of smell: ○ Increased ○ Normal ○ Decreased ○ Absent ○ Distorted

How often are you bothered by any of the following?	Always	Often	Rarely	Never
2. Food tastes different than it should because of a problem with odors.	○	○	○	○
3. I always have a bad smell in my nose, even if no odor source is present	○	○	○	○
4. Odors that are pleasant to others are unpleasant to me.	○	○	○	○
5. The biggest problem is not that I do not or only weakly perceive odors, but that they smell different than they should.	○	○	○	○

Screening Questionnaire for Loss of Taste

How easily can you detect the following tastes?

1. Saltiness in chips, pretzels, or salted nuts	☐ Easily	☐ Somewhat
2. Sourness in vinegar, pickles, or lemons	☐ Easily	☐ Somewhat
3. Sweetness in soda, cookies, or ice cream	☐ Easily	☐ Somewhat
4. Bitterness in coffee, beer, or tonic water	☐ Easily	☐ Somewhat

AllergyCorp Group
Dimitri Z Pitovski, MD

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Printed Name:_____ Date: _____

Signature:_____

Signature of Parent / Guardian:_____