The Allergy Group

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Board Certified in Pediatric and Adult Allergy, Asthma & Immunology
Website: www.theallergygroup.com
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Clinics in Boise, Nampa, Meridian & Eagle
Phone: 208.377.4000 Fax: 208.375.8426

Dear _____

Your appointment has been made for _____@_____
Your initial visit could last up to 2-3 hours.

ANTIHISTAMINES will block allergy testing results. Therefore, we ask that you NOT take any prescription-strength antihistamines (Claritin, Zyrtec, Allegra, Clarinex , and Astelin nasal spray) for 7 days prior to your visit. Over-the-counter non-prescription strength antihistamines like Benadryl may be taken up to 24 hours prior to your appointment.

DO NOT STOP any needed medications, asthma medications, topical or nasal steroids, stomach acid blockers, or Singulair.

Please have the patient information sheet filled out and make a list of the medications you take and the ones you may be allergic to and bring them with you for your appointment. Have all records that may be useful to us (doctor records, Emergency Room visits, lab tests, x-rays, etc.) either brought to us by you or have them faxed to our office **(208-375-8426)**.

Please be sure to bring your insurance cards and photo ID with you at the time of your visit. As a courtesy we do our best to check your insurance benefits before your first appointment to give you an estimate of expected charges and amount due from you. If for some reason this has not been done please notify our office before your appointment so that your insurance benefits can be checked. Regardless of Insurance status, you are directly responsible for payment of your account.

We ask that you pay your co-payment or amount owed at the time of each visit. Your balance is due in full 45 days from your initial visit, to be paid either by you and/or your insurance company. All professional services are rendered to the patient and **NOT** to the insurance company. Unless you pay the account in full at the time of service, the insurance money must be paid directly to our office. In case of family problems or disputes, the parents or person who brings a minor patient into the office is directly responsible for the account. Our office will not be involved in family disputes. If payment is a hardship for you, please call our office in advance of your appointment and speak with our office manager to make individual financial arrangements. There is a charge of $20 for each returned insufficient funds check. For your convenience, we accept **ALL** major credit cards.

A block of the doctor's time has been reserved for **YOU**. Our office will call to confirm your appointment 48 hours prior to your appointment. If you cannot keep an appointment, please give us **48 HOUR'S NOTICE**. This will allow someone else to be seen at that time. If you miss your appointment **WITHOUT** notification, a **"NO SHOW VISIT"** may be charged to you, which cannot be billed to your insurance.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE. WE WILL DO OUR VERY BEST TO RESOLVE YOUR ALLERGY PROBLEMS.

Thank you

The Allergy Group
experienced • capable • friendly

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1000 N. Curtis Rd.
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Email: Info@theallergygroup.com
Website: theallergygroup.com

Patient Information

Patient Name:_____ SSN: _____ - _____ - _____ DOB: _____ Sex:____
First Middle Initial Last MM/DD/YYYY

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Email: _____

Employer: _____ Address:_____ City: _____ State: ____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____ Relation to Patient: _____

Primary Care Provider: _____

Preferred Pharmacy: _____ Address/ or Cross Streets _____

Consent to pull pharmacy medication history? Yes____ No ____

Race: _____ Ethnicity: ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Refuse to Report

Primary Language: _____ Limited English Proficiency: Yes____ No ____

Who referred you to our clinic or how did you hear about us? _____ Veteran: Yes____ No____

Parents or Guardians (If Minor)

Name:_____ SSN: _____ - _____ - _____ DOB: _____ Sex:____
First Middle Initial Last MM/DD/YYYY

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Relation to Patient: _____

Name:_____ SSN: _____ - _____ - _____ DOB: _____ Sex:____
First Middle Initial Last MM/DD/YYYY

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Relation to Patient: _____

Insurance-Primary

Insurance Name: _____ ID Number: _____ Group Number: _____

Subscriber Name:_____ SSN: _____ - _____ - _____ DOB: _____
First Middle Initial Last MM/DD/YYYY

Insurance-Secondary

Insurance Name: _____ ID Number: _____ Group Number: _____

Subscriber Name:_____ SSN: _____ - _____ - _____ DOB: _____
First Middle Initial Last MM/DD/YYYY

Financial Agreement and Authorization for treatment

I authorize treatment of the named above and agree to pay all fees and charges for such treatment. I agree to pay all for myself and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed apon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/We agree to pay reasonable attorney's fees or such cost as the court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pend ency of claims thereon, all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

Signature:_____ (Type first and last name if electronic signature) Date: _____

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NEW PATIENT QUESTIONNAIRE

Name:_____ Age:_____ DOB:_____ Date:_____
Referred By: _____ Primary Care Provider:_____

History of present illness:

1. What allergy problem(s) do you have? (please circle)

Runny/stuffy nose	Sinusitis	Insect Allergy	Eye or ear problems
Asthma	Eczema/Rash	Drug Allergy	Headache
Cough	Hives or swelling	Food Allergy	Frequent Infections

Other_____
The major problem you wish to discuss today is: _____

2. List all prescription and over-the-counter medications you are currently using (**Name & Dosage**):

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

What medications have you tried for your allergy problems in the past? _____
_____
Are you allergic to any medications? If so, list drug, type of reaction and when: _____
_____
_____

3. Symptoms (please check all that applies)
   a. **Eyes**: Itch___ Swell___ Burn___ Tear___ Discharge___ Dry___
   b. **Ears**: Itch___ Fullness___ Popping___ Decreased hearing___ Pain___ Ringing___
   c. **Nose**: Sneeze___ Itch___ Runs___ Stuffy___ Mouth breather___ Snoring___ Yellow/Green drainage___ Decreased smell___ Decreased taste___
   d. **Throat**: Itch___ Sore___ Post nasal drip___ Throat clearing___ Swelling___ Hoarseness___
   e. **Lungs**: Cough___ Phlegm___ History of Asthma___ Wheezing___ Chest tightness___ Shortness of breath with exercise___ **Heartburn**___
   f. **Head**: Headaches? Yes/No Migraines? Yes/No What part of head?_____ How often?_____
   g. **Skin**: Eczema___ Hives___ Swelling___ Rashes___ Where on the body?_____

2. Respiratory Allergies
   a. Age of onset of your allergies_____, and/or asthma_____.
   b. Do you have daily symptoms?_____
   c. Which seasons are your allergies or asthma worse? (circle) Spring/Summer/Fall/Winter/All Year
   d. Does any particular exposure make you worse? (please check all that applies)
      Weather changes___, Dampness, Fragrances/Odors___, Smoke___, Dust___, Cosmetics/Aerosols___, Mold___, Cats/Dogs/Other animals___, Grass/Mowing___, Weeds___, Trees___, Exercise___, Anger/Stress___, Coughing/Laughing___, Colds/Respiratory infections___, Cold air___, Foods/Drinks___ (what? _____)
      Other:_____

e. Do you get sinus infections (yellow/green nasal drainage, pain etc..)? _____ How often?_____
How is it usually treated?_____
f. Have you had nose or sinus surgery? (when?)_____
g. Have you ever had ear tubes or a tonsillectomy? (when?)_____
h. Have you been told by a physician that you have nasal polyps?_____
i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing?_____

If you have Asthma:

j. Do you use a spacer device for inhalers?_____ Do you use a nebulizer?_____
k. Have you required maintenance inhalers? If so, which ones have you used? _____
_____
l. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergies or asthma? If so, how many times? _____
m. Have you ever been hospitalized for your asthma?_____
n. How many times in the past 12 months have you been to the ER with asthma?_____
o. How many puffs per week of your quick relief inhaler (albuterol) do you use?_____
p. Do you wake up at night coughing or requiring your inhaler?_____

3. Insect Allergy
   a. Have you had a severe allergic reaction to a stinging insect? Yes/No
   b. Did it cause a large local reaction? ____ OR cause hives, itching, or swelling all over the body? ____

4. Food Allergy
   a. Please list all foods and reactions they cause:_____
   _____
   _____
   b. Have you had hives before? (when and for how long?) _____
   c. Do you have a history or currently suffer from eczema? _____
   d. Are you sensitive to latex or rubber products? (explain)_____

Previous Allergy Evaluation & Treatment:

1. Name of Allergist and city: _____
2. Were you tested for allergies by skin prick test or blood test? If so, when: _____
3. Have you ever received Allergy Shots? If so, when and for how long? _____

Past Medical History:

1. Medical Problems: (Please circle)

High Blood Pressure	Diabetes	Thyroid Problem	High Cholesterol	Heart Disease
Abnormal Chest x-ray	Sleep Apnea	Glaucoma	Stomach ulcer	Hiatal hernia
Heartburn/Reflux	Cancer	HIV/AIDS	Hepatitis	Positive TB test
Depression	Arthritis	Blood Transfusion	Kidney disease	Prostate

   Other:_____
2. Please list all surgical operations and hospitalizations that you have had: _____
   _____
3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results)_____
   _____
4. Are you up to date on all recommended vaccinations?_____
5. Do you receive yearly flu vaccines? When was last? _____
6. Have you received a pneumonia vaccine? When? _____

Family History:

1. Which of your relatives have allergies or asthma? (please circle) Mother/Father/Sister/Brother/Children
   Are there any hereditary diseases or other disorders in your family? _____
   _____

Personal & Environmental History

1. Do you currently smoke tobacco? (How much and for how long?) _____
2. Have you ever smoked? (How much and for how long?)_____
3. How much alcohol do you drink? _____Do you use recreational drugs?_____
4. Do you have any animals in the home? (Type and how long?)_____
5. Do you have mostly wall-to-wall carpeting in your home?____ How old is your carpet? _____
6. What type of mattress/bedding do you have? (circle) Standard/Waterbed/Feather
7. What is your occupation? _____
   Are you exposed to any toxic chemicals, noxious substances at work? _____
8. How long have you lived in your current home?_____ How long have you lived in the Treasure valley area? ____
9. Do your symptoms become better while on vacation or while living somewhere else? _____
10. What are your daily activities/hobbies? _____

Review of Systems: (Do you have any of the following? Please check)

General
___Weight loss
___Fevers
___Night sweats
___Loss of appetite
___Dry mouth
___Snoring

Eyes & Ears
___Dry eyes
___Change in vision
___Trouble hearing
___Ringing in ears

Skin
___Skin rashes
___Frequent skin infections
___Abnormal skin lesions

Endocrine
___Cold/heat intolerance
___Increased thirst
___Frequent urination

Gastrointestinal
___Nausea/Vomiting
___Diarrhea
___Change in bowel habits
___Trouble swallowing
___Heartburn

Cardiovascular
___Chest pain
___Chest pain with exercise
___Calf pain with exercise
___Ankle Swelling

Neurological
___Weakness/clumsiness
___Tingling/numbness of extremities

Psychological
___Fearful, anxious
___excessive worry
___Trouble sleeping
___Depression

Kidney
___Trouble starting urine
___Loss of urine with cough/sneeze
___Frequent nighttime urination

Blood
___Anemia (low blood count)
___Bleed or bruise easily
___Swollen lymph nodes

Musculoskeletal
___Morning joint stiffness/aching
___Painful swollen joints
___Muscle tenderness or pain
___Muscle weakness
___Abnormal bone density

Gynecological
___Excessive bleeding
___Changes in menstrual cycle
___Post-menopausal

Getting a yearly flu shot is the best way to prevent getting influenza. Influenza can be dangerous for people with allergies/asthma and other chronic diseases. We recommend a yearly flu shot for all our allergy patients who have no contraindications to this vaccine. Please ask us if you have any questions concerning the flu vaccine

Patient/Parent Signature_____
(Please type first and last name if electronic signature)

Medical Provider's Initials (indicates the form has been reviewed)_____Date_____