9433 N. Beach St. #111
Fort Worth, TX 76244
P: (817) 428-7000
F: (817) 428-7006

ADVANCED ALLERGY & ASTHMA ASSOCIATES

540 E. Southlake Blvd. #140
Southlake, TX 76092
P: (817) 410-2111
F: (817) 410-2113

www.AdvancedAllergy.com

WELCOME

Dear Patient,

Thank you for choosing **Advanced Allergy & Asthma Associates** for your allergy care needs. We realize patients have a choice when selecting a medical provider and are grateful that you have chosen us.

At Advanced Allergy our goal is to offer patient-centered, state-of-the-art treatment of allergies and asthma for the entire family in a friendly, respectful environment.

Patient-centered: Our providers and staff strive to actively involve patients and their families at every level of care. Educating our patients about their condition and available treatment options will enable them to make informed decisions. We believe this will empower patients and help us develop a treatment plan that is tailored to each individual patient's preferences, needs and values.

State-of-the-art: Our physician(s) are board certified in Allergy/Immunology and specifically trained to treat diverse allergic diseases. They take pride in keeping up with new medical developments in the field of allergy/immunology and endeavor to offer the latest treatment options to their patients.

Friendly: You will find that our staff is friendly and respectful. They make every effort to make your visit comfortable.

Sincerely,
Advanced Allergy & Asthma Associates
9433 N. Beach Street, Ste 111
Fort Worth, TX 76244
(817) 428-7000
OR
540 E. Southlake Blvd, Ste 140
Southlake, TX 76092
(817) 410-2111

NOTICE OF PRIVACY PRACTICES

We are required by applicable federal law to maintain the privacy of your protected health information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes permitted or required by law. We must abide by the terms of this Notice while it is in effect. It also describes your rights to access and control your PHI. This Notice takes effect July 1, 2013 and will remain in effect until we replace it.

We reserve the right to change the terms of the Notice at any time, provided such changes are permitted by applicable law. The new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes permitted or required by law. Following are examples of the types of uses and disclosures of your PHI that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. For example, we may disclose your PHI to another physician or health care provider (*e.g.*, a specialist or laboratory) who becomes involved in your health care.

Payment: Your PHI will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. For example, obtaining approval for a specific procedure may require that your PHI be disclosed to the health plan to obtain approval.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

Required by Law: We may use or disclose your PHI to the extent that is required by law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse/neglect or victims of abuse, neglect or domestic violence.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs. However, it is our policy that we DO NOT fill out any paperwork for worker's compensation or any other similar legally-established programs (ie. FMLA, Disability, etc.)

Your Authorization: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by

your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Disaster Relief: We may use and disclose your PHI to assist in disaster relief efforts.

Marketing: We will not use your PHI for marketing without your written consent. We will not sell your PHI without your written authorization.

Appointment Reminders: We may use your PHI to provide you with appointment reminders (voicemail, letters etc.).

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

2. YOUR RIGHTS

You have the right to inspect and copy your PHI. You may inspect and obtain a copy of your PHI for so long as we maintain the PHI. As permitted by federal or state law, we may charge you a reasonable fee.

You have the right to request a restriction of your PHI. You may ask us to place specific restrictions on the use or disclosure of any part of your PHI. We are not required to agree to a restriction that you may request. We will comply with any restriction on PHI that we have granted, unless that is needed to provide emergency treatment. We may not refuse a request to restrict the disclosure of PHI to health plans if you pay in full, out-of-pocket for the services for which the PHI relates.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your physician amend your PHI. You may request an amendment of PHI about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right be notified of any breach of unsecured PHI.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

If you want more information about our privacy practices, please contact us using the contact information listed below. If you are concerned that we have violated your privacy rights, you may file a complaint with the Secretary of Health and Human Services at the US Department of Health and Human Services or with us. We will not retaliate against you for filing a complaint.

Advanced Allergy & Asthma Associates

Fort Worth/Keller Location:
9433 N. Beach Street, Ste 111
Fort Worth, TX 76244
Tel: (817) 428-7000
Fax: (817) 428-7006

Southlake Location:
540 E. Southlake Blvd., Ste 140
Southlake, TX 76092
Tel: (817) 410-2111
Fax: (817) 410-2113

OFFICE POLICIES

Thank you for choosing **Advanced Allergy & Asthma Associates** for your allergy care needs. We realize patients have a choice when selecting a medical provider and are grateful that you have chosen us. Our staff strives to make your experience with us as comfortable as possible. Feel free to contact us if you have any questions about our policies and procedures.

APPOINTMENTS

We see patients by appointment only, which can be scheduled by contacting our office during regular business hours. When scheduling an appointment, please provide our patient coordinators with your identification, contact and insurance information and also the reason for your visit.

Before you are seen by the physician, we need to complete several administrative and clinical tasks. Plan to arrive at the office at least 15 minutes *prior* to your scheduled appointment. If you arrive 15 minutes or more *after* your scheduled time, we may reschedule your appointment. Please bring the New Patient Packet (already filled out), your insurance card and one form of photo identification (e.g., driver's license).

Any minor patient, who is to receive treatment, allergy testing or injections should always be accompanied by a parent or legal guardian and this authorized individual(s) is listed on the attached "Permission to Treat a Minor" acknowledgement form.

If you will not be able to keep a scheduled appointment, please let us know as soon as possible; at least 24 hours in advance of the scheduled appointment. We will charge a fee of $25.00 for appointments that are missed without notification. Missed appointment fees are patient responsibility and will not be charged to the insurance company. Repeated missed appointments without notice may result in discharge from the practice.

INSURANCE

We accept several commercial insurance plans, Medicare and Tricare. It is your responsibility to make sure that our providers are in your insurance plan network. As a courtesy to our patients, we are happy to file insurance claims on your behalf for most insurance companies. Patients are responsible for co-pays, deductibles, co-insurance and non-covered services at the time of service. Any service not paid for by your existing insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial. It is patient responsibility to inform us of any changes in their insurance coverage. Failure to do so may result in denial of insurance claim and the patient will be billed for the account balance. If you do not have insurance coverage, please call our office to discuss options, discounts and/or payment plans.

BILLING

We accept cash, personal checks, debit cards and major credit cards (MasterCard, VISA, American Express and Discover). Full payment is due at the time of the service. Checks should be made to **Advanced Allergy & Asthma Associates**. Checks not honored by your bank will be assessed a Returned Check fee. It is our policy to make reasonable attempts to collect outstanding patient balances. Accounts that are delinquent may be referred to a collection agency and/or attorney. These accounts may also be subject to interest and additional fees. All accounts must be current at the time of office visit.

MEDICAL RECORDS AND PAPERWORK REQUESTS

All medical records are the property of **Advanced Allergy & Asthma Associates**. You can request a copy of your medical records. To ensure privacy, request for copies of medical records must be made in writing using a release of medical information form. This must include your original signature and a copy of photo identification. There is no charge to have your records sent directly to another healthcare facility. Paper copies will incur a charge of $1.00 per page for the first 20 pages and $0.50 for each additional page.

We also receive requests for specific school/sports forms, letters and other paperwork (NOT worker's compensation or FMLA, disability, etc. related). We can provide most of these at no cost if requested during an office visit. Otherwise, request for special forms that are NOT worker's compensation, FMLA or disability related can be made

by contacting our office. Please include patient's name, date of birth and the contact information where the form/letter is to be sent. When completion of the form requires review of the medical chart, we may charge a fee based on the length/complexity of the form.

EMERGENCIES AND AFTER HOURS

If you believe you are having a **MEDICAL EMERGENCY, PLEASE CALL 911 IMMEDIATELY**. If you call our office after-hours, please leave urgent messages on our voicemail and we will return your call the next business day. If you think the issue is non-urgent, please call us back during regular business hours.

NON-EMERGENCY ILLNESS DURING BUSINESS HOURS

Again, if you believe you are having a **MEDICAL EMERGENCY, PLEASE CALL 911 IMMEDIATELY**. If you feel you need to be seen in the office for your non-emergency allergy-related illness, we may be able to provide you a same day appointment. Please call early in the day as these slots fill up quickly. If same-day appointment is not available, our staff will discuss your needs with the providers and determine what needs to be done. We may charge for consultation that takes place over the phone instead of an office visit.

PRESCRIPTION REFILLS

Please do not wait to order refills until you are out of your medication. Keep a track of your medication/refill needs. Refills can be requested by contacting your pharmacy directly. If you have refills left on your prescription, they should dispense the medication. If there are no more refills on your prescription, the pharmacy will contact our office for refill authorization. You may also request medication refills by contacting our office during regular business hours. If you missed your last follow-up appointment, a limited number of refills may be authorized until a new appointment.

FOODS AND PERFUMES

Because of the nature of our medical specialty, we ask that you refrain from bringing foods/beverages to the clinic and wearing perfumes/colognes when visiting our office. Many of our patients have severe food allergies and exposure to trace quantities of implicated food can trigger life threatening reactions. Perfumes and colognes can trigger asthma exacerbations in some of our patients.

OTHER

We request all our valued patients and their family members to –

- Be courteous to our staff and other patients.
- Be respectful of the facility and clinic equipment.
- Be honest about necessary health information.
- **ALL NEW AND RECURRING REFERRAL AUTHORIZATIONS NEEDED IS SOLELY THE PATIENT'S RESPONSIBILITY and any balance accrued from non-payment by the patient's insurance due to no up-to-date referral on file is also the patient's financial responsibility.**
- Inform our office of any changes in insurance coverage or contact information.
- Cooperate in observing safety regulations and office policies.

Our office reserves the right to terminate any physician/patient relationship, if or when our office policies are violated by said patient or their family member.

REVISED ~~6/16/2021~~ ~~3/7/2022~~ 2/29/2024

ALLERGY SKIN TEST INSTRUCTIONS

Allergy skin testing is used to detect allergies to inhaled allergens (like pollen, animal dander, dust etc.), foods, certain insect stings and some medications. The test involves introducing very small amount of allergens into the skin and observing for positive reactions 15-20 minutes later. The procedure for skin testing is called scratch or prick testing. A scratch/prick device, with a drop of the allergen on it, is used to prick the skin on your back/arm/forearm. In case of inhaled allergens, if you test negative to particular allergens, a second procedure MAY be performed. The second procedure is called intra-dermal testing and involves injecting a tiny amount of the allergen into the superficial layer of the skin on your arms. Each procedure takes about 30 minutes to complete. The information obtained from allergy skin testing will provide guidance for avoidance of allergens. It may also be used to formulate allergy shot extracts for the treatment of hay fever, asthma and/or insect sting allergies.

Please review the following instructions to make your allergy testing visit as efficient as possible —

1) Wear comfortable clothing with a shirt/top that can be easily removed to perform the skin testing on the back.
2) The testing may take up to an hour and 15 minutes. Additional time will be needed to discuss test results.
3) Rarely, allergic reactions can occur from skin testing. These reactions may consist of generalized itching/hives/flushing, itchy eyes/nose/throat, runny nose, sneezing, post-nasal drip, nasal congestion, nausea, vomiting, throat swelling, shortness of breath, coughing, wheezing, rapid heart rate, dizziness, passing out and in extreme cases anaphylactic shock. Emergency treatment will be required in cases of allergic reactions.
4) We request that you do not bring small children with you during a skin testing visit, unless they are accompanied by another adult who can sit with them in the waiting area.
5) Certain medications can interfere with the skin testing. To ensure accuracy of the test, following medications will need to be discontinued for the specified amount of time prior to the scheduled testing. If you have concerns about the safety of discontinuing your medications, please contact us or the prescribing physician.

DISCONTINUE 10-14 DAYS PRIOR (* - Do NOT discontinue w/o first consulting with the prescribing physician)

Amitriptyline (Elavil)*	Clomipramine (Anafranil)*	Hydroxyzine (Vistaril, Atarax)	Protriptyline (Vivactil)*
Amoxapine*	Cyproheptadine (Periactin)	Imipramine (Tofranil)*	Thioridazine (Mellaril)*
Chlorpromazine (Thorazine)*	Desipramine (Norpramine)*	Nortriptyline (Pamelor)*	Trifluoperazine (Stelazine)*
Clemastine (Tavist)	Doxepin (Zonalon, Silenor)*	Promethazine (Phenergan)*	

*** Do not discontinue without first consulting with the prescribing physician**

DISCONTINUE 5-7 DAYS PRIOR

Azelastine (Astelin, Astepro, Optivar)	Dexchlorpheniramine	Ketotifen (Alaway, other eye drops)
Brompheniramine (Dimetapp, Bromfed)	Dimenhydrinate (Dramamine)	Levocetirizine (Xyzal)
Chlorpheniramine (Many prescription and OTC medications, for e.g., ChlorTrimeton, Tussionex	Diphenhydramine (Benadryl, Triaminic, Pediacare and many other OTC medications	Meclizine (Antivert, Bonine, Verticalm and other OTC motion sickness medications
Cetirizine (Zyrtec)	Doxylamine (Unisom & other sleep aids)	Loratadine (Claritin)
Carbinoxamine (Palgic, Arbinoxa)	Emedastine (Emadine)	Olopatadine (Patanase, Patanol, Pataday)
Cyclizine (Marezine)	Epinastine (Elestat)	Pheniramine (Visine-A, other eye drops)
Desloratadine (Clarinex)	Fexofenadine (Allegra)	OTC medications with anti-histamines

DISCONTINUE 24 HOURS PRIOR

Cimetidine Tagamet	Famotidine Pepcid	Ranitidine Zantac

DO NOT DISCONTINUE Asthma inhalers (for e.g., Advair, Flovent, Symbicort etc.), steroid nasal sprays (for e.g., Flonase, Nasonex, Veramyst, etc.) and medications for other chronic medical conditions.

THE FIRST 7 PAGES ARE THE PATIENT'S COPY TO KEEP FOR THEIR RECORDS

Please fill out the following pages and bring with you to your appointment

Patient Information

Patient Name: _____ Date of Birth: _____ Sex: _____
Last First MI

Age: _____ SSN: _____ Primary Phone: _____ Alt. Phone: _____

Email: _____

Home Address: _____City:_____State:_____Zip:_____

Patient Employer: _____ Employer Phone: _____

Employer Address: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Alt. Phone: _____

Responsible Party (if different than patient)

Responsible Person Name: _____ Date of Birth: _____ Sex: _____
Last First MI

SSN: _____ Relationship to Patient: _____ Phone: _____

Home Address: _____
Street City State Zip

Guarantor Employer: _____ Employer Phone: _____

Employer Address: _____
Street City State Zip

Physician Information

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____

Primary Insurance

Primary Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____
Street City State Zip

Insurance Phone: _____

Policy Holder's Name: _____ Date of Birth: _____ Sex: _____
Last First MI

SSN: _____ Relationship to Patient: _____ Phone: _____

Employer: _____ Employer Phone: _____

Secondary Insurance (if applicable)

Secondary Insurance: _____ ID#: _____ Group #: _____

Insurance Address: _____
Street City State Zip

Insurance Phone: _____

Policy Holder's Name: _____ Date of Birth: _____ Sex: _____
Last First MI

SSN: _____ Relationship to Patient: _____ Phone: _____

Employer: _____ Employer Phone: _____

CONSENT TO TREAT

Patient Name: _____ Date of Birth: _____

I hereby give consent for the patient named above to be treated by providers at Advanced Allergy & Asthma Associates.

I acknowledge that Advanced Allergy & Asthma Associates will file insurance claims on my behalf and hereby authorize the release of any information required to process insurance claims and determine benefits. I authorize payment of benefits directly to Advanced Allergy & Asthma Associates for services rendered. I understand that I am financially responsible for all co-pays, deductibles, co-insurance, non-covered services and unpaid services. I understand that payments are due at the time of service.

I understand that if I require a **referral authorization** from my insurance company then I am responsible for ensuring that the referral approval/authorization is on file with Advanced Allergy & Asthma Associates before services are rendered. I further understand that in order for continuity of care, I am also responsible for ensuring that there is an up-to-date referral on file AT ALL TIMES. Should a referral authorization/approval expire and in the event that my insurance company will not back date or pay for the services provided by Advanced Allergy & Asthma Associates after said expired referral then I understand that I will be financially responsible for all co-pays, deductibles, co-insurance, non-covered services and unpaid services. I understand that payments are due at the time of service.

I understand that if a minor patient, a parent or legal guardian must be present in the building at all times in order for minor to receive treatment, testing, or injections. (Authorized individuals must be listed on attached Permission to Treat a Minor acknowledgement form)

I understand that delinquent accounts will be referred to outside collection agencies and subject to interest and additional fees.

All medical records are the property of Advanced Allergy& Asthma Associates. Any copies of medical records may be subject to a fee.

I authorize Advanced Allergy & Asthma Associates to call or mail me with communication regarding my healthcare. I understand the privacy risks of phone calls and mail.

I have received and reviewed the Office Policies of Advanced Allergy & Asthma Associates.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Print Name Relationship to patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

1. I acknowledge that Advanced Allergy & Asthma Associates has provided me a copy of their Notice of Privacy Practices and Office Policies. I have had the chance to review this Notice.
2. I authorize Advanced Allergy & Asthma Associates to use and/or disclose the protected health information (PHI) described below to my Personal Representative(s) named as follows:

   _____
3. This authorization for release of PHI covers all past, present and future periods of healthcare.
4. I hereby authorize the release of my complete health record (including records received from referring providers)
5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claim payment, or other purposes as I may direct.
6. This authorization to release information to my Personal Representative(s) will automatically renew yearly, following the date of this signed form.
7. I understand that I have the right to revoke this authorization, in writing, at any time.
8. I understand that my treatment, payment, or eligibility of benefits will not be conditioned on whether I sign this authorization.
9. I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Print Name Relationship to patient

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: O Individual refused to sign O Communication barriers prohibited obtaining acknowledgement O An emergency situation prevented us from obtaining acknowledgement O Other: _____ _____ _____ _____ Staff Name Staff Signature Date

New Patient History

Patient Name: _____ Date of Birth: _____ Sex: _____
Last First MI

Chief Complaint/Reason for Visit _____

Pharmacy: _____

Review of Systems (Circle all that apply) ☐ None

Constitutional: Fatigue Fever Chills Weight Gain Weight Loss Loss of Appetite
Eyes: Itching Redness Tearing Crusting of eyelids Circles around eyes Light sensitivity Pain Decreased vision
Ears: Itching Popping Congestion Pain Discharge Wax Cerumen Hearing loss Ringing Vertigo
Nose: Itching Sneezing Runny nose Congestion Bleeding Sinus pain/pressure Decreased sense of smell
Mouth: Itching Swelling of lips/tongue Cold sores Bad breath Mouth breathing
Throat: Itching Post-nasal drip Throat clearing Sore/dry throat Throat swelling Hoarseness Difficulty swallowing
Cardiovascular: Chest pain/pressure Radiation of pain Profuse sweating Palpitations/Irregular rhythm Heart murmur
Respiratory: Cough Sputum Shortness of breath Chest pain/tightness Wheezing Exercise intolerance
Gastrointestinal: Nausea Vomiting Diarrhea Constipation Bloating Abdominal pain Reflux
Skin: Itching Flushing Rash Hives Swelling Eczema
Allergic/Immunologic: Frequent infections Food reactions Insect sting reactions Drug reactions

Past Medical History (Check all that apply) ☐ None

☐ ADD/ADHD	☐ Anaphylaxis	☐ Anemia	☐ Angioedema/Swelling
☐ Arthritis	☐ Asthma	☐ Autism	☐ Bipolar disorder
☐ Cancer: _____	☐ Contact dermatitis	☐ COPD	☐ Cystic Fibrosis
☐ Depression	☐ Diabetes	☐ Eczema	☐ GERD(Heartburn/Reflux)
☐ Glaucoma	☐ Hay fever	☐ Heart disease	☐ Hepatitis
☐ HIV/AIDS	☐ Hives	☐ Hypertension	☐ Hypothyroidism
☐ Hyperthyroidism	☐ Immunodeficiency	☐ Kidney disease	☐ Migraine
☐ Nasal polyps	☐ Osteoporosis/Osteopenia	☐ Pneumonia	☐ Recurrent infections
☐ Sinusitis	☐ Stroke	☐ Substance abuse	☐ Tuberculosis
☐ High cholesterol	☐ Other: _____	☐ Other: _____	☐ Other: _____

Past Surgical History: List all surgeries you have had in the past ☐ None

_____

_____

Family History ☐ None

	Mom	Dad	Brother	Sister	Son	Daughter	Grandparent
Hay fever							
Asthma							
Food allergies							
Medication allergies							
Angioedema/Swelling							
Eczema							
Immunodeficiency							
Sinus disease							
Thyroid disease							
COPD							
Diabetes							
Heart disease							
Stroke							
Auto-immune disorder							
Cancer (Type)							
Hypertension							
Other							

Patient Name: _____ DOB: _____ Date of Appt: _____

Social/Environmental History

Do you presently smoke? ☐ Yes ☐ No If yes, how many packs/day: _____ How long: _____

Did you ever smoke? ☐ Yes ☐ No If yes, how many packs/day: _____ How long: _____

When did you quit? _____

Pets? What kind and how many? _____

Current Medications ☐ None

Medication	Strength	How Often	Reason

Allergies

Medications: _____

Reaction: _____

Foods: ☐ Milk ☐ Eggs ☐ Peanut ☐ Tree Nuts ☐ Fish ☐ Shellfish ☐ Wheat ☐ Soy ☐ Other:_____

Reaction: _____

Insect Stings: ☐ Fire Ant ☐ Honey Bee ☐ Wasp ☐ Yellow Jacket ☐ Hornet ☐ Other: _____

Reaction: _____

Latex: ☐ Yes ☐ No Reaction: _____

Previous Allergy Evaluation ☐ Yes ☐ No

Name of allergist: _____ Phone: _____

Allergy testing done previously? ☐ Yes ☐ No

If yes, when? _____ Any positive tests? _____

Have you received allergy shots? ☐ Yes ☐ No If yes, when and how long? _____

Did you benefit from allergy shots? _____ Any allergic reactions to shots? _____