Allergy Associates and Asthma, Ltd.
Asthma/Allergy

1006 EAST GUADALUPE ROAD, TEMPE, AZ 85283
6553 EAST BAYWOOD AVE., STE 103, MESA, AZ 85206
2248 NORTH ALMA SCHOOL ROAD, STE 104, CHANDLER, AZ 85224

SURESH C. ANAND, M.D., M.S. IN MED., F.A.C.P., F.C.C.P.
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MIRIAM K. ANAND, M.D., F.A.C.P., F.A.C.A.A.I., F.A.A.A.A.I.
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE

DIPLOMATES, AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

VEENA KRAUSE, F.N.P.

TERA CRISALIDA, P.A.-C., M.P.A.S.

TELEPHONE (MAIN OFFICE) (480) 838-4296 FAX (480) 820-1275
www.allergyassoc.net

Welcome To Our Practice!

We look forward to meeting you at your upcoming appointment.

Your initial appointment will typically last for **two to three hours**. Your appointment will consist of gathering in-depth medical and environmental information, a thorough examination and possibly conducting necessary tests which may include a breathing analysis, laboratory and allergy testing. However, a complex medical history or treatment plan will require an evaluation and second appointment to provide treatment on another day. We will work hard to provide you with the answers you need and a treatment plan that offers you relief.

In order to complete allergy testing, we ask that you are free of medications that contain antihistamine. You MUST be free of antihistamine **7 days** prior to your appointment. A list of medications containing antihistamines is included. It is important that you do not discontinue your daily medications, such as cardiac, respiratory, mood stabilizers, anticoagulant therapy, etc. If you have any specific questions about what medications to discontinue prior to your visit, please do not hesitate to call us at (480) 838-4296. This information can also be found at our website www.allergyassoc.net.

- All new patient paperwork must be completed prior to your appointment.
- If you are late for an appointment, we may ask you to reschedule.
- Please do not wear perfume, cologne, scented lotions or other fragrances.

Please provide the following information at the time of your consultation:

- Your current and correct insurance information. This will include all insurance cards and a photo I.D.
- Any x-rays, CT Scans, MRI Films, Hearing Tests or sleep studies (if applicable).
- A detailed list of medications which must include name of the drug, how many times a day you take it, how many you take in a day, why you take it and how long you've been taking it and the strength of the medication. This will include prescribed and over the counter medications.
- All copayments, coinsurance, fees and deductibles will be collected at the time of service. We accept cash, checks, Visa, MasterCard, American Express, and Discover Card. We also accept Care Credit. (carecredit.com)
- A parent or guardian must accompany all patients under 18.
- A referral from your Primary Care Physician if one is required.

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PATIENT INFORMATION

Thank you for choosing Allergy Associates and Asthma, Ltd. for your medical needs. We promise to do our best to provide you with the finest care available. If you have any questions, or need assistance filling out these forms before being seen, please do not hesitate to ask us.
Regular informational updates are required **yearly**
ALL FORMS MUST BE FILLED OUT COMPLETELY
Thank you for your cooperation.

PLEASE PRINT:

Patient Name: _____
(LEGAL NAME) *FIRST* *MIDDLE* *LAST*
Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Sex: M F Date of Birth:_____ Age: _____ Marital Status: M S W D

SSN Number: _____

Primary Care Physician (*first and last name*):_____ Phone: _____

Referring Physician (*first and last name*):_____ Phone: _____

In case of emergency who should be notified? _____ Relationship: _____ Phone: _____

If the patient is a minor: Father _____ Mother _____ Guardian_____

Employer: _____ Occupation: _____

Employment status: _____ Full Time _____ Part Time _____ Retired ____ Self _____ Active Duty ____ Not Employed

Are you a student? ___ Yes ___ No **If yes,** are you? ___ Part Time ___ Full Time What School?
_____

Whom can we thank for referring you to our office? _____

Are we currently seeing other members of your family? Yes____ No_____ Relationship:_____

How did you hear about our office? (Check all that apply)

☐ Referred by a Doctor ☐Referred by a Patient ☐Yellow pages ☐Website ☐Insurance Company ☐Other_____

Do you require an interpreter when meeting with the doctor? ☐ Yes ☐ No
Language/Languages: _____

The government now requires us to ask the following two questions:
How do you identify your ethnicity? (Please check one)
☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ I prefer not to answer

How do you identify your race? (Please check one)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White or Caucasian
☐ Native Hawaiian or Pacific Islander ☐ Other _____ ☐ I prefer not to answer

PREFERRED PHARMACY

Name: _____ Phone Number: _____

Location: _____

PATIENT PORTAL SETUP

OUR PORTAL WILL GIVE YOU THE OPPORTUNITY TO:

☐ Request an appointment
☐ View prescriptions and request prescription refills
☐ View Medical History
☐ Send messages and receive messages from our office via email
☐ View account balance and make a payment on your account
☐ View Patient Education Materials

Email address: _____(Please Print)

INSURANCE INFORMATION

Regular informational updates are required annually. All forms must be filled out completely.

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relationship to patient:__ Self __Spouse __Child __Other

Date of Birth: _____ Social Security # of the policy holder: _____

Employer: _____

Insurance Company: _____ Benefits/Eligibility Phone#:_____

Insurance Claims Address: _____ City: _____ State:_____ Zip Code: _____

Member ID#:_____ Group #: _____ Plan #: _____

SECONDARY INSURANCE

Name of Policy Holder: _____ Relationship to patient:__ Self __Spouse __Child __Other

Date of Birth: _____ Social Security # of the policy holder: _____

Employer: _____

Insurance Company: _____ Benefits/Eligibility Phone#:_____

Insurance Claims Address: _____ City: _____ State:_____ Zip Code: _____

Member ID#:_____ Group #: _____ Plan #: _____

TERTIARY INSURANCE

Name of Policy Holder: _____ Relationship to patient:__ Self __Spouse __Child __Other

Date of Birth: _____ Social Security # of the policy holder:_____

Employer: _____

Insurance Company: _____ Benefits/Eligibility Phone#:_____

Insurance Claims Address: _____ City: _____ State:_____ Zip Code:_____

Member ID#:_____ Group #: _____ Plan #: _____

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ASSIGNMENT AND RELEASE

Thank you for choosing Allergy Associates and Asthma, Ltd. for your medical needs. We promise to do our best to provide you with the finest care available. If you have any questions, or need assistance filling out these forms before being seen, please do not hesitate to ask.

Regular informational updates are required **yearly**

ALL FORMS MUST BE FILLED OUT COMPLETELY

Thank you for your cooperation.

Please complete this form in its entirety. Your insurance card must be brought to every visit. You are required to notify us if there have been any changes to your insurance.

AGREEMENT TO PAY: In consideration for the services rendered and to be rendered by Allergy Associates & Asthma, LTD to the patient, I (we) agree to pay Allergy Associates & Asthma, LTD for all services and charges as are ordered by the attending physician in accordance with the terms and policies of Allergy Associates & Asthma, LTD. If the services are not covered by private or government insurance, I (we) agree to pay Allergy Associates & Asthma, LTD its standard non-discounted rate for the services provided. I (we) understand that Allergy Associates & Asthma, LTD will make available to me (us) upon request, a schedule of the standard charges for the services. I (we) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made, pay collection costs, including court costs, reasonable attorney fees and interest from the date of demand, if this account is placed for collection.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign to Allergy Associates & Asthma, LTD and the attending physician(s), expenses or other surgical or treatment expenses and benefits which are due, or to become due to me as a result of medical services to the patient listed below. I hereby authorize the payments to be paid directly to Allergy Associates & Asthma, LTD for any services furnished by the physicians or certified physician assistants under their supervision. I understand that I am responsible to Allergy Associates & Asthma, LTD for payments made directly to me and for any services or charges not covered by my insurance carrier(s).

CONSENT TO TREATMENT: I hereby voluntarily consent to medical care to include diagnostic procedures and medical treatment judged necessary by my physician or his designee. I acknowledge that no guarantees have been made to me as a result of this treatment. In addition to all other consents given elsewhere in this document, I specifically consent to medical procedures and tests necessarily performed upon me to aid and assist in the diagnosis and treatment of myself/and or my child.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Allergy Associates & Asthma, LTD and all physicians involved in my care to release information from my medical records as may be required to any person, corporation or agency which is legally responsible or which Allergy Associates & Asthma, LTD has good cause to believe is legally responsible, for processing and/or paying all or any part of Allergy Associates & Asthma, LTD charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize Allergy Associates & Asthma, LTD or any physician involved with my care to release information to any physician or health care facility to which I may be transferred for further medical care.

_____ Date _____
Signature of Patient (or Parent/Guardian for minor)

_____ Date _____
Witness (Employee of Allergy Associates & Asthma, LTD)

COMMUNICATION CONSENT

Patient Name: _____ DOB: _____
PLEASE PRINT NAME

We may call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave messages on your home phone?

☐ **Yes** ☐ **No** **Home Number:**

_____

Can we leave messages on your cell phone?

☐ **Yes** ☐ **No** **Cell Phone:**

_____

Can we mail test results to your home?

☐ **Yes** ☐ **No**

We may call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding medications, treatment, lab results, prescription refills, or other issues regarding your health?

1 _____
NAME RELATIONSHIP

2 _____
NAME RELATIONSHIP

My signature below authorizes my communication consent choices.

_____ _____
Patient Name (please print) Date

_____ _____
Patient or Person Authorized to Sign Date

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PATIENT WORKSHEET FOR CONTACTING INSURANCE COMPANY

The following questions are suggested in order to find out how your insurance company will cover **allergy treatment** in our office. When contacting your insurance company, it is important to have your medical insurance card out, as the insurance company will need this in order to assist you.

1 Is the provider (physician) you are seeing at our office a contracted provider with your insurance company? YES_____ NO_____
If no, then your coverage may be limited.

2 Are there pre-existing limitations? YES_____ NO_____
If yes, then you may not be eligible for coverage until the pre-existing waiting period ends. You will want to clarify this pre-existing clause with your insurance company.

3 Does your insurance company require your family practice physician to refer the patient to our practice? YES_____ NO_____
If yes, then you will need to contact your family physician for this referral.

4 We are a specialist office. Is a specialist office visit subject to:
Deductible? YES_____ NO_____ Co-Pay? YES_____ NO_____

5 Is allergy testing (CPT Code 95004) subject to:
Deductible? YES_____ NO_____ Co-Pay? YES_____ NO_____

6 Is there a limit as to the number of allergy tests that can be done on a given date?
YES_____ NO_____
If yes, how many tests are allowed? _____ What is the time frame?_____

7 What is the expected patient's financial responsibility for this new patient office visit and the allergy testing? _____

8 Does your insurance company have a drug prescription formulary?
YES_____ NO_____

9 What is the name of the person who provided the benefit information?
NAME: _____ DATE: _____

Please bring this worksheet to your first visit.

Allergy Associates and Asthma, LTD.
FINANCIAL PAYMENT POLICY FOR PATIENTS

At Allergy Associates and Asthma, LTD. we pride ourselves on providing our patients with the best medical care available, in a warm and friendly office setting. Your cooperation with our stated financial policy enables us to focus our attention on your medical needs, and improves the operation of this practice to better serve you.

- **Insurance** – Your insurance policy is a contract between you and your insurance company. The doctor is not involved in this contract. You are contractually responsible for your co-payment, co-insurance deductible, or any balance unpaid at the time of service. We accept Cash, Check, Visa/MasterCard, Discover, Amex, and Care Credit.

- **No Insurance** – Patients who are self-pay are responsible for the entire balance at the time of service.

- **Regarding Insurance** – We may accept assignment of insurance benefits. We will bill your insurance company upon receipt of your current insurance information. **If your insurance company has not paid your account in full within 45 days, the balance may automatically be billed to you**. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Non-covered services will be billed to the patient.

- **Medicare Medical Necessity** – Medicare will pay only for services that it determines to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular service, although it would otherwise be covered is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment you are personally and fully responsible for payment.

- **Cancellation Policy** – Our providers want to be available for your needs. Unfortunately, when a patient does not show for their scheduled appointment another patient loses an opportunity to be seen. If you are unable to make your appointment please call us at least 24 hours before your scheduled appointment time otherwise a fee of $50.00 will be billed directly to you. This policy enables us to better utilize availability of appointments for our patients in need of medical care.

- **Cobra Plan** - If you are on a Cobra plan that cannot be verified at your time of visit we will ask you for payment in full for services until verification is established.

- **Payments Plans** – We are able, at any time, to set up a reasonable payment plan. Please don't hesitate to ask.

- **FMLA Forms, Disability Forms and Insurance Forms** – Form completion is <u>not</u> a covered benefit under any plan. There will be a $ 25.00 charge for completion of all FMLA, Short-term and Long-term Disability forms. Payment is due before forms are completed.

- **Minor Patients –** For all services rendered to minor patients, the adult accompanying the minor is the responsible party on the child's account. All co-payments, co-insurance and deductibles are due at the time of service. If there is a remaining balance due on the account after the insurance payment is received a statement will be sent to the responsible party. We will not bill non-custodial parents, shared custodial parent, or any other third parties. Any outside financial arrangement between you and the child/children's parent does not include our practice.

- **Returned checks** – There is a $40.00 fee if your check is returned unpaid. In addition, any future services will require cash or credit card payments.

Allergy Associates and Asthma, LTD.

FINANCIAL PAYMENT POLICY FOR PATIENTS

- **Statements** – Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date.

- **Collections** – Should it be necessary to place your unpaid account with our outside collection agency, you must communicate directly with them. Additionally, you will be responsible for all fees plus 40% to collect a debt. If sent to collections, we will not be able to see you.

- **Insurance Coverage** – It is the patient's responsibility to know their insurance coverage benefits and present their card at each visit. We ask that you contact your insurance carrier to review your benefits prior to being seen. Although you may receive a pre-authorization number from your insurance company, this does not guarantee that your insurance company will pay for the service.

I have read, understand and agree to abide by the financial policy of Allergy Associates and Asthma, Ltd.

X _____ _____

(Print) Patient or Responsible Party Date

X _____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include referrals to specialists or diagnostic services or treatment facilities.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your health care insurance plan for your medical services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION TO ORGANIZATIONS that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary:

(a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or
(c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other use and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

For more information about our Privacy Practices, please contact:

Brianne, Practice Administrator
Allergy Associates & Asthma, LTD
1006 E. Guadalupe Road
Tempe, AZ 85283
480-838-4296

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

I hereby confirm that I understand or have received a copy of Allergy Associates & Asthma, Ltd's Notice of Privacy Practices.
I understand that it is my responsibility to familiarize myself with the contents of the Notice.

_____ _____

Patient / Guardian (Please Print) Date

_____ _____

Patient / Guardian Signature Date

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Tempe	Mesa	Chandler	Page #
Dr. Suresh Anand	Dr. Miriam Anand	Veena Krause, F.N.P.	Tera Crisalida, PA-C

Patient's Name:	Date:	Paper Referral:

Date of Birth:	Chart number:	Auth #	Expired Date:

Initial Visit Form to be filled out by the Patient

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

APPR. DATE STARTED	MEDICATION:	DOSE:	FREQUENCY:	PRESCRIBING DOCTOR:

DRUG ALLERGIES & REACTIONS: _____

OCCUPATION:	**HOBBIES:**

Medications tried in the past for your allergies?	**Helped?**
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure
	Yes No Not sure

For Staff Use Only: **Formulary**:

Smoker? Never / Current / Former

Pets? No / Yes

Type/Number of pets: _____

CC: _____

HT	**WT**	**P**	**BP**	**pO_2**	**Temp/other:**

_____

_____

_____ _____

Staff initials

Patient Name: Account #: Date:

If you have asthma please take this **Asthma Control Test** (ACT).

This survey was designed to help you describe your asthma, and the way your asthma affects how you feel and what you are able to do. To complete it, please mark and "X" in the box that best describes your answer to each question.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done as usual at work, school, or at home?

☐1	☐2	☐3	☐4	☐5	☐
All of the time	Most of the time	Some of the time	A little of the time	None of the time	**Score**

2. During the past 4 weeks, how often have you had shortness of breath?

☐1	☐2	☐3	☐4	☐5	☐
More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all	**Score**

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

☐1	☐2	☐3	☐4	☐5	☐
4 or more nights a week	2 to 3 nights a week	One night a week	One or two nights in the last 4 weeks	Not at all	**Score**

4 During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

☐1	☐2	☐3	☐4	☐5	☐
3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all	**Score**

5. How would you rate your asthma control during the past 4 weeks?

☐1	☐2	☐3	☐4	☐5	☐
Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled	**Score**

Total score: ☐

To score the Asthma Control Test (ACT): Each response to the 5 ACT questions has a point value from 1 to 5 as shown on the form. To score the ACT, add up the point values for each response to all five questions.

If your total point value is 19 or below, your asthma may not be well controlled. Be sure to talk to your health care professional about you asthma score.

For more information on the ACT, or for help interpreting or scoring the test, visit www.qualitymetric.com

ALLERGY ASSOCIATES & ASTHMA, LTD.		
1006 E GUADALUPE RD **TEMPE, AZ 85283** **PHONE: (480) 838-4296** **FAX: (480) 820-1275** **www.allergyassoc.net**	**SURESH C. ANAND, M.D.** **MIRIAM K. ANAND, M.D.** **VEENA KRAUSE, F.N.P.** **TERA CRISALIDA, PA-C**	**2248 N ALMA SCHOOL RD, STE 104** **CHANDLER, AZ 85224** **6553 E BAYWOOD AVE, STE 103** **MESA, AZ 85206**
IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 24 HOURS NOTICE		
ALLERGY QUESTIONNAIRE	**Patient's Name:**	**Account No.**
OCCUPATION:	**DATE:**	

Please try to answer these questions accurately as the information is of considerable importance to your allergist in the evaluation of your condition. If you have difficulty with any of the questions, check with the medical assistant who will see you after you have completed this form.

What is your main reason for coming to see an allergist?

_____

_____

_____

When did this problem start? _____

How severe is the problem? ☐ mild ☐ moderate ☐ severe ☐ other:_____

Is the problem present most of the time? Yes No (circle one) If it is only present occasionally, how often does it occur?

_____

Is it worse during certain months? Yes No (circle one) If yes, please list which months:

_____

What relieves the problem? _____

What makes it more severe? _____

What other related symptoms are you having? _____

_____

Where were you living when the problems started? _____

If you have moved since the symptoms began, list the cities or areas in which you have lived and indicate to the right of each area whether symptoms were unchanged, less severe, or more severe in that area.

AREAS	SEVERITY OF SYMPTOMS

What other symptoms do you have that you believe are due to allergies?

_____

Have you been studied or treated by an allergist in the past or has any other physician done allergy skin tests or given injections for allergy. Yes No (circle one) Specify years and details:

_____

Read the following list carefully and indicate by checking in the appropriate boxes to the left of each item, which items cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. Even a small change is significant. Leave all boxes blank if you have never encountered the situation or item.

Cause or Aggravate	Relieve	No Change	ITEMS
☐	☐	☐	Lawn mowing, grass contact
☐	☐	☐	Weed contact, specify: _____
☐	☐	☐	Blossoming trees, specify: _____
☐	☐	☐	High winds, riding in auto with open windows
☐	☐	☐	Raking leaves
☐	☐	☐	Musty, moldy or mildewed places or articles
☐	☐	☐	Going indoors
☐	☐	☐	Going outdoors
☐	☐	☐	Sweeping, dusting, vacuuming in the house, dusty books, etc.
☐	☐	☐	Any animals, specify: _____
☐	☐	☐	Taking any medications (including aspirin, etc.) specify: _____
☐	☐	☐	Emotional upset
☐	☐	☐	Exertion or heavy exercise, specify: _____ _____
☐	☐	☐	Respiratory infection, virus infection, flu
☐	☐	☐	Insect spray
☐	☐	☐	Hair spray, cosmetics, talcums, aftershaves, perfumes, etc. specify: _____ _____
☐	☐	☐	Air conditioning, swamp coolers, etc. specify: _____
☐	☐	☐	Antihistamines or nasal decongestants (Allegra, Claritin, Zyrtec, etc.) specify: _____
☐	☐	☐	Medications for wheezing (Albuterol, Maxair, Serevent, etc.) specify: _____
☐	☐	☐	Adrenalin or Epinephrine
☐	☐	☐	Steroids (Cortisone type drugs, i.e. nasal sprays and/or inhalers) specify: _____
☐	☐	☐	Other drugs, specify: _____
☐	☐	☐	Very cold weather or changes in weather
☐	☐	☐	Trips to the mountains
☐	☐	☐	Trips to the desert
☐	☐	☐	Trips to the seashore
☐	☐	☐	Any other trips out the this area, specify place and time of year _____ _____
☐	☐	☐	Menstrual periods and/or pregnancy, specify: _____
☐	☐	☐	Tobacco smoke
☐	☐	☐	Anything else you have noticed, specify: _____

Have you ever had any of the following conditions? If so check the appropriate boxes & specify during which years (and if applicable, seasons) and in what area you were living at the time, if you have not already answered these above.

☐ Hay fever

☐ Nasal allergy all year (“sinus”)

☐ Asthma (wheezing, shortness of breath) describe: _____

_____

☐ Hives, urticaria, angioedema (facial swelling, etc.) Circle appropriate word or words.

☐ Eczema

☐ Skin rash due to allergy or contact, specify cause: _____

☐ Poison oak, ivy or sumac rash, specify which ones: _____

☐ Food Allergy, specify foods and what symptoms they cause. Specify and describe any other unusual reaction when you eat any particular food: _____

Drug allergy (specify the drugs and the symptoms which occur: ☐ None that I know of

_____

_____

Unusual reaction to insect bites or stings. (Specify the insects, describe the reactions and give the dates when they occurred):

_____

_____

PAST MEDICAL HISTORY: Have you had in the past or do you currently have any of the following? (Please check the appropriate box.)

☐ Diabetes
☐ cataracts
☐ osteoporosis/osteopenia
☐ glaucoma
☐ Thyroid disease (high or low)
☐ bleeding from the gastrointestinal tract
☐ autoimmune disease (e.g., lupus, rheumatoid arthritis)
☐ ulcer of the stomach or duodenum
☐ COPD, chronic bronchitis, or emphysema
☐ high blood pressure
☐ GERD or acid reflux or hiatal hernia
☐ Stroke
☐ pneumonia
☐ bronchitis
☐ heart attack
☐ Valley Fever
☐ tuberculosis
☐ sleep apnea
☐ Cancer Type:_____ How treated: ☐ chemotherapy ☐ radiation ☐ surgery
☐ Other _____

When was your last flu shot? _____
If 65 or older have you had a pneumonia vaccine: Yes No

PAST SURGICAL HISTORY: Please list all surgical procedures that you have had and list the ***approximate*** dates. (Include tonsillectomy.)

Type of surgery	Approximate date of surgery
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR DIAGNOSTIC TESTS: Have you ever had any of the following exams?

Test	Response	Approx. date of last test	Finding	
Colonoscopy	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
Mammogram	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
Chest x-ray	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
CT scan of sinuses	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
Cardiac stress test	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
Bone mineral density test	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
Prostate biopsy or blood test	☐ Yes ☐ No		_____	☐ normal ☐ abnormal
Skin biopsy	☐ Yes ☐ No		_____	☐ normal ☐ abnormal

If any of the above were abnormal, please explain:

_____

_____

Do you / did you ever smoke? ☐ Yes ☐ No f so, how much and what?_____
For how many years? _____ When did you quit? _____

FAMILY HISTORY: In your family as listed, did anyone have any of the following numbered conditions? Indicate the number to the right of the appropriate blood relative: (e.g., patient's mother 1, 6, 11)

Patient's mother

Patient's father

Patient's brothers or sisters

Patient's maternal aunts or uncles

Patient's maternal grandparents

Patient's paternal aunts or uncles

Patient's paternal grandparents

Patient's children

1. Hay fever
2. Nasal allergy
3. "Sinus"
4. Asthma
5. Hives
6. Eczema
7. Food allergy
8. Drug allergy
9. Insect allergy
10. Emphysema or other lung diseases
11. Diabetes
12. Tuberculosis
13. Lupus
14. *Rheumatoid* arthritis
15. Thyroid disease
16. Leukemia
17. Lymphoma
18. Other cancer
19. Immunodeficiency

REVIEW OF SYSTEMS: Please check if you have any of the following:

GENERAL: ☐ None ☐ unexplained weight gain or loss ☐ unexplained fevers or shaking chills
☐ waking up with your bedsheets or nightclothes soaking wet with sweat

SKIN/BREASTS: ☐ None ☐ Breast lumps ☐ Nipple discharge ☐ Hives ☐ Eczema
☐ Other rashes: _____

EYES/EARS/NOSE/MOUTH/THROAT: ☐ None ☐ Headaches ☐ Lightheadedness ☐ Visual changes
☐ Nosebleeds ☐ dentures or partials ☐ hoarseness ☐ tightness in the throat or choking sensation

CARDIOVASCULAR: ☐ None ☐ palpitations/racing or fluttering of heart ☐ heart murmur ☐ irregular heart rhythm
☐ swelling of the feet/ankles ☐ shortness of breath when lying flat

RESPIRATORY: ☐ None ☐ shortness of breath ☐ wheezing
☐ Cough If yes, do you bring up mucous? ☐ No ☐ Yes If yes, what does it look like? ☐ clear ☐ whitish
☐ dark yellow/green/brown Other: _____ Do you cough up blood? ☐ Yes ☐ No

GASTROINTESTINAL: ☐ None ☐ Nausea ☐ Vomiting ☐ abdominal cramping ☐ diarrhea ☐ blood in stool
☐ heartburn (burning in the stomach, chest, or throat) ☐ taste of vomit in the mouth without vomiting
☐ food sticking when swallowing ☐ impaired liver function

GENITOURINARY: ☐ None ☐ blood in urine ☐ trouble urinating ☐ history of kidney stones
☐ waking up more than 3 times at night to urinate ☐ impaired kidney function

MUSCULOSKELETAL: ☐ None ☐ red, hot swollen joints ☐ pain in joints ☐ arthritis

NEUROLOGIC/PSYCHIATRIC: ☐ None ☐ seizures ☐ anxiety ☐ depression ☐ thoughts of suicide

LYMPHATIC: Have you noticed any enlarged or swollen lymph nodes that won't go away? ☐ No ☐ Yes
If yes, where? ☐ neck ☐ over the collar bones ☐ armpits ☐ borders between thigh and pelvis

ADDITIONAL HISTORY THAT YOU WANTED US TO KNOW:

_____

_____

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Asthma/Allergy

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Medications to Be Stopped Prior to Testing

Please be aware that some medications and/or herbal supplements that you may be taking can interfere with the skin test results. Please take a moment to review the list of medications that should be discontinued prior to your first appointment or before you receive any skin testing. Please call us if you have questions about which medications to stop.

***Note: DO NOT discontinue any antibiotics, heart medications, insulin or other medications prior to consulting your physician.**

Below are some allergy and asthma medications that you DO NOT NEED TO DISCONTINUE:
- **Singulair (montelukast)**
- **Inhaled corticosteroids (e.g., Advair, Symbicort, Qvar, Dulera)**
- **albuterol**
- **Most nasal Sprays (e.g., Nasonex, Veramyst, most nasal sprays) – see below for those that need to be stopped**
- **pseudoephedrine (e.g., Sudafed)**
- **phenylephrine**

- **ANTIHISTAMINES MUST BE STOPPED unless otherwise directed and are in numerous medications that treat varied conditions other than allergies, including, but not limited to:**

-Insomnia	**-Acid Reflux**	**-Nausea**
-Anxiety	**-Coughs & Colds**	
-Depression	**-Varied Eye Conditions**	

Oral Medications that contain the following should be discontinued at least ***7 days*** prior to skin testing or new patient appointments:

1- loratadine (e.g., Claritin, Alavert, other generic store brands)
2- fexofenadine (e.g., Allegra, other generic store brands)
3- cetirizine (e.g., Zyrtec, other generic store brands)
4- desloratadine (e.g., Clarinex)
5- levocetirizine (e.g., Xyzal)
6- **Herbal supplements** including green tea, licorice, saw palmetto, St. John's Wort, and Fever few

Oral Medications that contain the following should be discontinued at least ***3 days*** prior to skin testing or New Patient Appointments:

1) acrivastine (e.g., Semprex-D)
2) azatadine (e.g., optimine, Trinalin)
3) brompheniramine (e.g., Bromfed, Children's Dimetapp Cold & Allergy)
4) carbinoxamine (e.g., Rondec Syrup)
5) chlorpheniramine (e.g., Chlor-Trimeton, Triaminic cold & Allergy)
6) clemastine (e.g., Tavist)
7) cimetidine (e.g., Tagamet)
8) cyproheptadine (e.g., Periactin)
9) diphenhydramine (e.g., Benadryl, Tylenol PM, many sleep aids)
10) dexbrompheniramine (e.g., Dimetapp Cold & Allergy)
11) dexchlorpheniramine (e.g., Polarmine, Tanafed DP)
12) doxepin (e.g., Sinequan, Zonalon)
13) famotidine (e.g., Pepcid, TUMS Dual Action)
14) hydroxizine (e.g., Atarax, Vistaril)
15) nizatidine (e.g., Axid)
16) prometnazine (e.g., Phenergan)
17) ranitidine (e.g., Zantac)

*__18)__ amitriptyline (e.g., Elavil,Vanatrip)
*__19)__ clomipramine (e.g., Anafrnil)**.....**
*__20)__ imipramine (e.g., Tofranil)**.....**
*__21)__ nortryptiline (e.g., Aventyl)**.....**
*__22)__ protriptyline (e.g., Vivactil)**.....**

**DO NOT DISCONTINUE THESE MEDICATIONS WITHOUT CONSULTING YOUR PHYSICIAN. **

Eye Drops that contain the following should be discontinued at least ***3 days*** prior to skin testing or new patient appointments:

1 azelastine (e.g., Optivar)
2 emedastine (e.g., Emadine)
3 levocabastine (e.g., Livostin)
4 pheniramine (e.g., Naphcon-A, Visine-A)
5 olopatadine (e.g., Patanol, Pataday)
6 ketotifen (e.g., Zaditor, other generic store brands.)
7 bepotastine (e.g., Bepreve)

Nasal Sprays that contain the following should be discontinued at least ***3 days*** prior to skin testing or new patient appointments:

1 azelastine (e.g., Astelin, Astepro, Dymista)
2 olopatadine (e.g., Patanase)

PLEASE CALL US WITH ANY QUESTIONS ABOUT WHICH MEDICATIONS TO STOP