Allergy/Asthma Specialists W. MI

Board Certified Pediatric and Adult Allergy-Immunology
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Patient Registration Form

Welcome To Our Office! To assist us in your care, please fill out all areas of this form which apply to you. Thank You!

Patients Name: _____Sex: M / F
First **Middle** **Last**
Home Address: _____ City: _____
State: _____ Zip: _____ Birthdate: _____
SSN: _____Telephone: ( )_____Work #: ( )_____
Cell Phone: _____Marital status: S M W D
IS THIS A REFERRAL VISIT? Yes or No

NAME OF PRIMARY CARE PROVIDER: _____
Address or Phone: _____
PREFERRED PHARMACY: _____
Address or Phone: _____

*****IF NOT REFERRED BY A PRIMARY CARE PROVIDER:**
Do you want us to send a letter to the primary care provider? **Yes** or **No** (circle one)
How did you learn about our practice? _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
(complete if address is different)
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( )_____

PRIMARY INSURANCE
Name of Insurance Company: _____ Phone #: _____
Policy Holder's Name: _____ P.H. Birthdate: _____
Group #: _____ Policy ID: _____ SSN#: _____
Policy Holder's Address(if different): _____
City: _____ State: _____ Zip: _____ P.H. Phone#_____
Employer: _____ Employer Phone #: _____
Emplyment Status: Full Time: ____ Part Time: ____

SECONDARY INSURANCE
Name of Insurance Company: _____ Phone #: _____
Policy Holder's Name: _____ P.H. Birthdate: _____
Group #: _____ Policy ID: _____ SSN#: _____
Policy Holder's Address(if different): _____
City: _____ State: _____ Zip: _____ P.H. Phone#_____
Employer: _____ Employer Phone #: _____
Emplyment Status: Full Time: ____ Part Time: ____

EMERGENCY CONTACT
(Someone who can get in touch with you if we cannot)

Contact: _____ Relationship: _____

Home Phone: ( ) _____Work Phone: ( ) _____Cell Phone: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Signature of Patient or Responsible Party: _____Date: _____

I request payment be made to Allergy/Asthma Specialists W. MI. The undersigned is responsible for all fees, regardless of insurance coverage. A copy of this authorization is as valid as the original.

Signed:

_____

(Patient or responsible party)

Date: _____

*****ONLY SIGN THIS SECTION IN OUR OFFICE AT CHECK-IN**

I acknowledge that I have received a copy of the Notice Regarding Privacy of Personal Health Information of Allergy/Asthma Specialists W. MI.

Signed:_____
(Patient or responsible party)

Date:_____

Allergy/ Asthma Specialists W. MI
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PLEASE COMPLETE BEFORE YOUR APPOINTMENT

NAME:_____ **Date:**_____**Primary care provider:**_____

1 **Circle 3 to 5 most bothersome NASAL / EYE SYMPTOMS:** (IF NONE, SKIP)

Runny nose Stuffy nose Sneezing Discolored nasal discharge throat clearing
Post nasal drip Itchy nose Rubbing nose Loss of smell Loss of taste
Mouth breathing Snoring Sniffling Red eyes Cough
Itchy eyes Watery eyes Dry eyes Puffy eyes Rubbing eyes
Headaches
Other:_____

***How long have you had these symptoms?_____**

Medications tried for nose and eye symptom: (pills, nasal sprays, eye drops, other)

Name of drugs	How long tried?	helped	Some help	No help

2 **Ever diagnosed with ASTHMA? (circle)** NO / YES- when diagnosed:_____

- IF NO, Ever been given asthma medications, inhalers, breathing treatments? NO / YES
  - ✓ *If YES*, which ones:_____

Circle up to 5 most bothersome CHEST SYMPTOMS: (IF NONE, SKIP to **3**)

Trouble breathing Chest tightness Frequent cough Cough at night Wheezing
Morning cough Cough or wheeze with exercise/play Cough after eating Rattly chest
Other:_____

-Does exercise/activity trigger cough or wheeze? (circle) NO / Sometimes / Often

-**Typically** has nighttime or early morning cough NONE/ **____**(enter#) times a week.

- Any HOSPITALIZATIONS for **asthma** or other **breathing** problems? NO / YES
  - ✓ *IF YES:* How many times?_____ When was that last time?_____
    Ever in ICU (intensive care unit)? NO / YES when?_____
- Any ER/URGENT CARE visits for **asthma** or other **breathing** problems? NO / YES
  - ✓ *IF YES:* How many times?_____ When was that last time?_____
- Any PREDNISONE / ORAL STEROID PILLS or syrups for **breathing** flare? NO / YES
  - ✓ *IF YES:* How many times?_____ When was that last time?_____
- **Quick relief inhaler used** (like Albuterol, Proventil, Ventolin, Maxair) _____ times a month / week / day
- **Spacer?** □ No □ Yes □ with mouthpiece □ with facemask
- Does the Quick Relief inhaler help? NO / YES
- **Peak Flow Meter?** □ No □ Yes, typically runs _____ .

3 **Symptoms are: Year-round OR/AND Worse during (circle months)**

NOSE/EYES: Year Round / Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Chest/Asthma: Year Round / Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4 ALLERGY SURVEY

a. Previous Allergic Investigation –
By whom _____When_____
Results of test _____
Immunotherapy □ No □ Yes →Any significant reactions? □ No □ Yes → _____
Duration _____ Did shots help? _____
Reason Treatment stopped _____

b. Occupational History—
Employer_____
Specific Job_____
Difference in symptoms at work/home_____
Change in symptoms on vacation _____

IF CHILD:
In Daycare/Preschool?_____
Since when? _____
____days per week

c. Living Accommodations –
□ House □ Apartment □ Mobile Home • □ City □ Town □ Country
Age of home _____ Years lived in this location _____
Prior occupants with pets? □ No □ Yes: _____
Basement: □ Yes □ No • □ Finished □ Carpet □ Damp □ Dry □ Dirt
Heating: □Forced Air □Space Heat □Hot Water □Wood Burn □Gas □Electric
Air Conditioning: □Yes □No • □Central □Unit □Room
Humidifier: □Yes □No • □Central □Unit • Dehumidifier: □Yes □ No
Bedroom—
Sleeps on: □Mattress □Waterbed
Pillow: □Foam □Feather □Polyester
Stuffed Animals in bedroom: □Yes □No
Floor: □Carpet □Wood □Linoleum
Living Room—
Floor: □Carpet □Wood □Linoleum

(Continued)—
Water leak problems □No □Yes:
Obvious mold problems □No □Yes:

d. Pets? – □YES □NO
□Outdoors □Indoors What kind?_____
How long have you had the pets? _____

□ Exposure to friends'/relatives' pets? What kind?_____
Symptoms around pets: _____

e. Smoking Exposure? – □YES □NO
□Patient □Father □Mother □Spouse □Others
Prior smoking? □No □Yes: how long ___yrs; packs per day ___ When stopped: _____

f. Allergy to Food? – □YES □NO
Food _____ Reaction: _____
Food _____ Reaction: _____

g. Allergy to Medications? – □YES □NO
Medication _____ Reaction: _____
Medication _____ Reaction: _____

h. Severe Insect Stings Reactions?— □YES □NO □ NEVER BEEN STUNG
□ Large Swelling □Hives on other parts of the body □Breathing problems □Dizziness or fainting
□Other:_____

5 **Check triggers:**

	Nose/Eyes	Chest		Nose/Eyes	Chest		Nose/Eyes	Chest
Dust			Tobacco smoke			Food		
Mowed grass			Colds/Viruses			Exercise		
Pets: (what kinds)			Strong Odors			Cold air		
			Wind			Humid days		
Weather changes			Stress			Air conditioning		
Others:			Raking leaves			perfumes		

Family history (please check all that apply):

	Father	Mother	Brother(s)	Sister(s)	Children
Migraine					
Hives					
Emphysema					
Asthma					
Eczema					
Hayfever/Nasal Allergies					
Thyroid Disease					

6 **LIST ALL CURRENT MEDICATIONS & SUPPLEMENTS** and how often you take them.

_____
_____
_____

7 **REVIEW OF SYSTEMS**: (Please circle all that pertain):

Heart: Heart murmurs palpitations irregular heartbeat other heart conditions
GI: Heart burn/reflux Diarrhea constipation gas abdominal pain cramps bloating
GU: Bedwetting incontinence frequency urgency
Skin: Diaper rash cradle cap thrush eczema hives
Hives: Triggers- stress cold exercise hot shower vibration pressure points sun

8 **PAST MEDICAL HISTORY:** (Please circle all that pertain)

Nasal polyps / Facial Trauma /Migraines / Frequent Sinusitis / Thyroid Problems / Stomach Acid Reflux / Tuberculosis / Compromised immune system /Heart Disease / High Blood Pressure / Arthritis / Joint Problems / Osteoporosis

***[If A Child*:** Pregnancy/delivery: Full-term / Premature Growth and Development: Normal / Vomiting / Spitting
Immunizations: Up-to-date / Flu shot / Pneumovax/ missing:_____ **]**

Surgeries: tonsils / adenoids / sinuses / ear tubes / other:_____

Hospitalizations: _____ ER Visits:_____

Any Other Important Medical History?:_____

******Please bring in ANY INHALERS, PEAK FLOW METERS, AND SPACERS.******