Allergy & Asthma Physicians, S.C.

Name: _____ SS # _____

Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ **Home Mobile Work** Additional Phone: _____ **Home Mobile Work**

Birthdate: _____ Marital Status: _____ Student? no full time part time

Who is your Primary Care Doctor: _____

Address: _____ Phone: _____

Who referred you: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who is responsible for payment*? Address, if different: _____

*(If patient is a minor)

❖ **PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST**. ❖

Insurance Company: _____ Do you want us to bill your insurance? yes no

Please circle: PPO Medicare HMO Other if HMO: Amita Loyola (MacNeal) if Other: _____

Group #: _____ Subscriber ID #: _____

Primary Subscriber: _____ Relationship to insured: **Self Spouse Child**

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

I authorize the release of any medical information necessary to process my insurance claim to my insurance company. I authorize the payment of medical benefits to Allergy & Asthma Physicians, unless otherwise noted. I understand that Allergy & Asthma Physicians will bill my *primary* insurance as a courtesy to me. Any balance that remains unpaid after 45 days will be my responsibility.

Signature: X _____ Date: _____

I acknowledge receipt of Allergy & Asthma Physicians Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Allergy & Asthma Physicians has reserved a right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: X _____ Date: _____

Relationship, if not patient: _____

PATIENT NAME:_____ DATE: _____ D.O.B_____

Please answer **all** questions on the following **three** pages to the best of your ability.

1.) Briefly describe the problem(s) which have caused you to see the doctor today. _____
_____

2.) Has your child ever been hospitalized or seen in the emergency room for this/these problem(s)? Yes____ No__
(If yes, state when.) _____

3.) Which time of day are your child's symptoms worse? (circle) Morning Afternoon Evening Nighttime

4.) Do the symptoms ever awaken your child at night? Yes___ No_____ If yes, how often?_____

5.) Are the symptoms worse during certain seasons? Yes____ No____

If yes, which season? (circle) Winter Spring Summer Fall

7.) Are your child's symptoms triggered or worsened by exposure to any of the following **allergens**? (circle)
Dust Pollens Cats Dogs Mold (raking leaves, hay rides, damp basements) Other _____

8.) Are your child's symptoms triggered or worsened by exposure to any of the following **irritants**? (circle)

Smoke Perfumes Strong Odors Cold Air Exercise Other _____

9.) Please list other factors which you feel are associated with triggering your child's symptoms. _____

10.) Please list the names of **all** medications your child is currently taking, including over the counter_____
_____

11.) Please list any drug allergies: _____

Other physicians your child has seen for this/ these problems: _____ _____

PAST HISTORY

Birth History

Born where? _____ Birth Weight :_____
Length of Pregnancy _____ Any complications with delivery?_____

Feeding History

Breast (how long?)____ Formula _____ Any troubles with feeding (vomiting, gas, diarrhea, etc.)? _____

Immunizations

(Up to Date?)_____
Any adverse reactions ? _____

Illnesses

Has your child ever been **diagnosed** with any of the following? (Please check **YES** or **NO**)

	YES	NO	Physician Comments
Asthma	_____	____	
Hay fever/ Allergic Rhinitis	_____	____	
Sinus Problems	_____	____	
Ear infections/ fluid in ears	_____	____	
Eczema/ Dermatitis	_____	____	
Bronchitis	_____	____	
Bronchiolitis	_____	____	
Pneumonia	_____	____	
Chicken Pox	_____	____	
Measles	_____	____	
Croup	_____	____	
Arthritis/ Joint aches	_____	____	

Other: _____

Any Surgeries? _____

Any Blood Transfusions? Yes No
Any Hospitalizations? _____

Reviewed By _____ M.D.

PATIENT NAME:_____ DATE: _____ D.O.B_____

ENVIRONMENTAL SURVEY
Please **check** or **complete** the answers to describe your home.

Type of Home: House____ Apartment____ Other_____

Approximate age of home: _____ years Years of occupancy_____

Location: City____ Suburban____ Country____

Near your home is there a: Barn___ Prairie___ Factory____ Other_____

Obvious mold/mildew? Yes / No Lots of dust? Yes / No Roaches? Yes / No

Heating System: Forced Air___ Radiator___ Baseboard___ Other_____

Air Conditioning: Central___ Window units___ Fans___ How often do you change the air filter?_____
In the spring / summer / fall windows are primarily kept: Open ____
Closed ____

Floor coverings: Carpet___ Area rug___ Wood___ Other_____

Is there a basement or crawl space? Yes___ No ___ Is the basement damp or musty? Yes___
If yes, do you spend much time in the basement? ___Yes ___No No ___

BEDROOM
Located in : Basement___ First Floor___ Second Floor___ Attic___

Floor Covering Carpet___ Area rug ___ Wood___ Other_____

Bed mattress: Conventional___ Futon ___ Water___

Pillows: Synthetic/Foam____ Feather/Down_____

Comforter: Cotton/Synthetic _____ Feather/Down _____ Wool ____

Household Pets: Cat_____ Dog_____ Bird_____ Other_____
Do they go into the bedroom? Yes___ No___

SMOKERS IN FAMILY No **Yes** (who?)

Did Parent or Caretaker previously smoke around the child (at home, in car, in restaurants)? **No** **Yes** (Who)?

PARENT's OCCUPATION: Mother_____ Father_____

SCHOOL HISTORY:
Does or did your child attend daycare or pre-school ? _____

How many days of school (day care) per year has your child missed due to illness ?_____

Does your child have symptoms during gym class or other activity ? _____

Does your child take any medications at school (day care) ? _____

Is your child exposed to any of the following at school (day care) ? **(circle)**

Animals (rabbits, mice, etc.) Dusts Chemicals Smoking Other_____

Reviewed By _____ M.D.

PATIENT NAME:_____ DATE: _____ D.O.B_____

Family History: Please **check** all that apply to members of your family.

	Mother	Father	Siblings	Other Relative	Physician Comment
Allergic Rhinitis(Hay Fever)					
Asthma					
Sinus Problems					
Nasal Polyps					
Hives/ Swelling					
Eczema/ Dermatitis					
Drug Allergy					
Food Allergy					
Stinging Insect Allergy					
Emphysema/ COPD					
Chronic Bronchitis					
High Blood Pressure					
Heart Disease					
Diabetes					
Thyroid disorder					
Cancer					
Other _____					

Review of Systems:
Please **circle** any of the following symptoms which your child is **currently experiencing** or which caused **serious** problems in the past.

General: fever, night sweats, weight changes, fatigue, loss of appetite

Eyes: itching, tearing, dry eyes, redness, swelling, discharge

Ears: ear fullness, popping, itching, loss of hearing, infections

Nose: sneezing, itching, runny nose, stuffy/congested, yellow/green discharge

Throat: sore throat, post nasal drip, itchy palate

Lymph glands: glandular swelling, glandular tenderness

Chest: cough, nighttime cough, wheezing,
frequent respiratory infections, shortness of breath

Intestinal Tract: nausea, vomiting, indigestion, trouble swallowing,
stomach pain, constipation, diarrhea, excessive gas

Urinary: trouble with urination, frequent urination, burning, urinary infections,

Rheumatologic: joint stiffness, joint swelling, joint pain,

Skin: rash, hives, welts, itching, eczema, hair loss

Neurologic: black outs, severe headaches, epilepsy(seizures),
inability to concentrate, trouble sleeping

Other: All Others Neg.____

Reviewed By _____ M.D.