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: _____

(Adult)

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.) Have you 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 symptoms worse? (circle) Morning Afternoon Evening Nighttime

4.) Do your symptoms ever awaken you at night? Yes_____ No_____ If yes, how often?_____

5.) Are your symptoms worse during certain seasons? Yes___ No___

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

7.) Are your symptoms triggered or worsened by exposure to any of the following **allergens**? (circle)

Dust Pollens Cats Dogs Mold (raking leaves, hay rides, damp basements etc..) Other _____

8.) Are your 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 symptoms. _____

10.) Please list the names of **all** medications you are currently taking, including "over the counter" _____
_____

11.) Please list any drug allergies _____

Other physicians you have seen for this/ these problems: _____ _____

Past Medical History

Childhood: (Circle) Infections: ears, throat, sinuses, chicken pox, measles, mumps, Other _____

Have you ever been **diagnosed** with any of the following ? (Please check **Yes** or **No**)

	YES	NO	Physician Comments
Asthma	____	____	
"Hay Fever"/ Allergic Rhinitis	____	____	
Eczema/ Dermatitis	____	____	
Sinus Problems	____	____	
Chronic Bronchitis	____	____	
Emphysema/ COPD	____	____	
Pneumonia/ Pleurisy	____	____	
Infectious Mononucleosis ("Mono")	____	____	
Heart Disease/ Angina	____	____	
High Blood Pressure	____	____	
Cancer (Type:_____)	____	____	
Thyroid Disorder (over or under active)	____	____	
Diabetes	____	____	
Liver disease or Hepatitis	____	____	
Ulcer (Stomach or Duodenal)	____	____	
Kidney disease	____	____	
Colitis	____	____	
Rheumatic Fever	____	____	
Arthritis (Joint Pain or Stiffness)	____	____	

Other_____

What surgeries have you had? (Please include tonsils/ adenoids): _____

Any problems with anesthetics? YES NO Any blood transfusions? YES NO

Have you received the following immunizations?

	YES	NO	Unsure
1) Influenza (Yearly Flu Shot)	___	____	_____
2) Tetanus (within last 10 years)	___	____	_____
3) Pneumonia shot (Pneumovax)	___	____	_____

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___ No ___
If yes, do you spend much time in the basement? ___Yes ___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 HOME: No Yes (who?)

OCCUPATIONAL HISTORY

What is your current occupation?_____

How many days of work (school) missed per year due to illness? _____
Are you exposed to any of the following at work (school)? (circle)
Smokers Animals Vapors/gasses Dust Chemical sprays Other irritants_____

SOCIAL HISTORY

Smoking/ Tobacco:
Current Smoker: Yes ____ No ____
Former Smoker: Yes ____ No ____
packs/day _____
age started _____
age stopped _____
Vaping/e-cigs/Other (explain) _____

Marital Status: Single _____ Married ____
Widowed_____Divorced_____
Number of Children _____

Did you grow up in a home with smokers? ___Yes ___No

Place of Birth_____
Other states you have lived in:

Alcohol Use: Rare/Never_____ Occasional _____ Frequent (daily)_____
Caffeine: No__ Yes__ (how much?)_____
Hobbies/Exercise: _____

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	Children	Other Relative	Physician Comment
Allergic Rhinitis(Hay Fever)						
Asthma						
Sinus Problems						
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 you are **currently experiencing** or which have caused you **serious** problems in the past.

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

Eyes: itching, tearing, redness, dry, swelling, discharge, contact lenses, cataracts, glaucoma

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

Nose: sneezing, itching, runny nose, stuffy/congested, discharge , loss of smell

Throat: sore throat, post nasal drip, itchy palate

Lymph glands: glandular swelling, glandular tenderness

Chest: wheezing, cough, short of breath, chest pain, palpitations

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

Urinary: urinary infections, frequent urination, prostate problems

Rheumatologic: joint stiffness, joint swelling, joint pain, osteoporosis, fractured bones

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

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

Endocrine: heat intolerance, cold intolerance

Female History irregular periods, breast disease
Are you or could you be pregnant now? YES NO

Have you been on birth control pills within the last year? YES NO

Reviewed By _____ M.D.