

**ALLERGY, ASTHMA & CLINICAL
IMMUNOLOGY ASSOCIATES
ALLERGY ASSOCIATES OF CENTRAL INDIANA**

Diplomates of The American Board of Allergy and Immunology
(A Conjoint Board of The American Boards of Internal Medicine and Pediatrics)

Pinkus Goldberg, M.D.

Douglas J. Horton, M.D.

Steven L. Wise, M.D.

Dear: _____

This is to confirm your appointment.

DATE: _____ DOCTOR: _____

APPOINTMENT TIME: _____ OFFICE: _____

ARRIVAL TIME: _____ TELEPHONE: _____

Thank you for choosing Allergy, Asthma and Clinical Immunology Associates for an allergy/asthma evaluation. To determine whether or not your symptoms are due to allergies, it is very important for us to know what substances you are exposed to in your environment and how they have been possibly bothering you. **Therefore, please complete the attached questionnaire before your appointment, and bring it with you.** When answering the questions, try to relate them to your own experiences and observations, not merely the results of previous skin tests or the advice of other physicians.

In order that your examination is as thorough as possible, please allow **at least 2-1/2 to 3 hours for the examination** . . . we recommend a good meal before your examination.

DO NOT take Loratadine (the generic name for Claritin) for 7 days before the appointment; other non-prescription antihistamines or decongestants for a full 72 hours prior to your appointment. If you are on prescription antihistamines, stop the medication 7 days before the appointment. Stop decongestants 3 days before the appointment. DO NOT stop any medications you are taking for asthma. Phone us if you have any questions about the medications that you are taking.

To prevent misunderstandings, we recommend you fax your Insurance information completed on the attached form plus a copy of your insurance card, front and back, to (317) 924-8270 prior to your appointment date. In addition, you must present your insurance card the date of the appointment. Payment is due at the time of service without a valid insurance card, unless prior arrangements have been made.

Not all insurances will fully reimburse the expenses for allergy testing. Please call your insurance company if you believe this may be a problem. Please bring in all insurance cards and appropriate forms.

If you have a managed care plan insurance (HMO), please hand carry the referral form, or have the authorization faxed to (317) 924-8270 so there will be no misunderstanding about authorized services and payment. You may also call (317) 924-8285 for assistance with your referral requirements

If possible, please contact any physician who has cared for the health problem for which you are seeing us and ask their office to forward your records (copies of x-ray reports, CT scan reports, and pertinent lab results). Send records to 3266 N. Meridian St., Indianapolis, IN 46208 or have them faxed to (317) 924-8239.

Thank you for your cooperation. If you have any questions, please feel free to contact our office. We look forward to seeing you.

We reserve the right to bill you for failed appointments.

Sincerely,

Pinkus Goldberg, M.D.

Douglas J. Horton, M.D.

Steven L. Wise, M.D.

Web page: allergyindy.com

This questionnaire mailed out by _____ on _____.

Allergy Associates Voice Mail Selections



RECEPTIONIST AVAILABLE FROM 9-12 AM AND 1-5 PM: (317) 924-8297 or (800) 358-3944

AFTER HOURS: (317) 924-8295 (to reach voice mail only—for medical emergency dial 911)

1. PATIENT SCHEDULING, press 1
 - A. Appointments for Dr. Goldberg, Press 1
 - B. Appointments for Dr. Horton or NPs Karleen or Jennifer, Press 2
 - C. Appointments for Dr. Wise, Press 3
 - D. Practice Manager, Press 5
 - E. Receptionist, Press 0

2. NURSES, PHYSICIANS, MEDICATION REFILLS and ALLERGY EXTRACT, Press 2
 - A. Medication Refill, Press 1
 - B. Message for Nurse or Physician, Press 2
 - C. Allergy Serum Orders, Injection Questions, Press 3
 1. Extract Technician, Press 1
 2. Mixing Nurse, Press 2
 3. Instructions for Ordering Serum, Press 4
 4. Receptionist, Press 9
 - D. Practice Manager, Press 4
 - E. Receptionist, Press 9

3. CLINICAL RESEARCH, Press 3

4. OTHER OPTIONS, Press 4
 - A. Human Resource Department, 317-924-8256
 - B. Billing and Insurance, 317-924-8334
 - C. Referrals and Authorizations, 317-924-8285
 - D. Requests for Medical Records, Press 5
 - E. Practice Manager, Press 6

5. REPLAY MENU, Press 5

Operator or receptionist is not available after hours. Dial 924-8297 to reach answering service.

Web page: allergyindy.com

BILLING INFORMATION (Guarantor/Parent or Guardian of Dependent):

Name: _____
 First _____ Middle _____ Last _____

Address: _____
 Street _____ APT. _____ City _____ State _____ ZIP _____

Area Code & Phone Number _____ Cell Phone _____ Relationship To Patient _____

PATIENT INFORMATION:

Name: _____
 First _____ Middle _____ Last _____

Address: _____
 Street _____ APT. _____ City _____ State _____ ZIP _____

Area Code & Phone Number _____ Emergency Contact Person _____ Emergency Contact Phone Number _____

DOB _____ / _____ / _____ Male or Female _____
 Month Day Year Marital Status Social Security # Cell Phone _____

Primary Care Physician _____ Referral required from PCP? Yes NO Referring Physician if different _____

Employer Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____ Ext. _____

PRIMARY INSURANCE: *Must be completed in full along with a photo copy of the insurance card. **EFFECTIVE DATE:** _____

Insurance Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____

GROUP # _____ POLICY # _____ Relationship to Subscriber: _____

Subscriber Name _____ DOB _____ SS# _____

Employer Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____ Ext. _____

SECONDARY INSURANCE: * Must be completed in full along with a photo copy of the insurance card. **EFFECTIVE DATE:** _____

Insurance Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____

GROUP # _____ POLICY # _____ Relationship to Subscriber: _____

*Patients with MEDICARE as a secondary payor must provide the reason why Medicare is a secondary policy for the patient. Please CIRCLE one of the reasons below:

(12) Working Age Beneficiary/Spouse with Employer Group Health Plan (13) End Stage Renal (14) No Fault Insurance (15) Worker Compensation

(41) Black Lung (42) VA Veterans Administration (43) Disabled Beneficiary under 64 with Group Health Plan (47) Any other Liability Insurance

Subscriber Name _____ DOB _____ SS# _____

Employer Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____

APPLIES TO MEDICARE PATIENTS ONLY: I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize my holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. APPLIES TO MEDIGAP PATIENTS ONLY: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize any holder of medical information about me to release to my _____ insurance any information needed to determine these benefits payable for services.

(Insurance Co. Name)

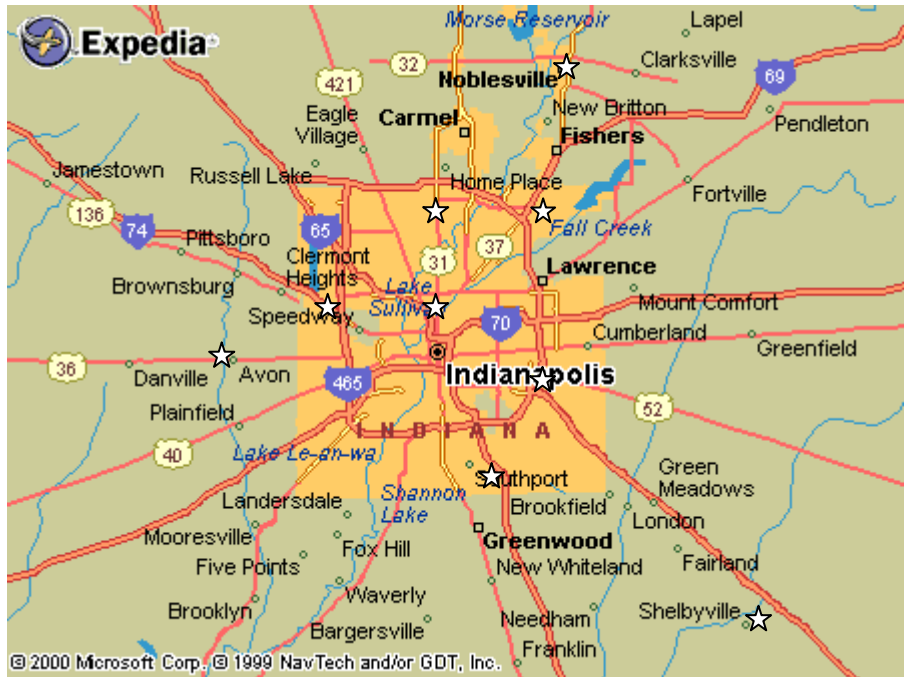
ALL PATIENTS and/or GUARANTOR: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time as revoked by me. In the case of default payment, I promise to pay any legal interest on the balance due together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of Patient or Guarantor _____ Date _____

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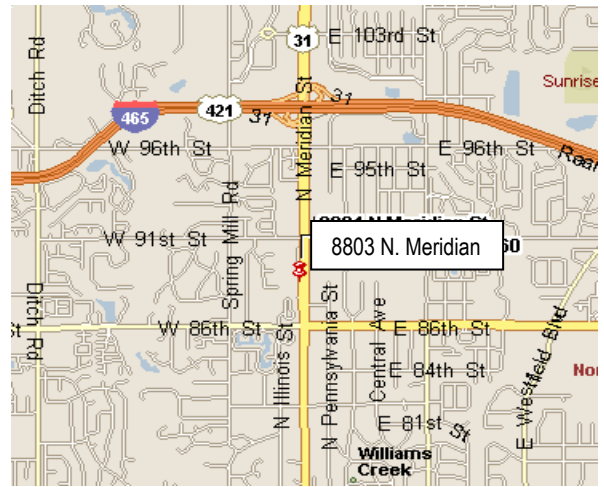
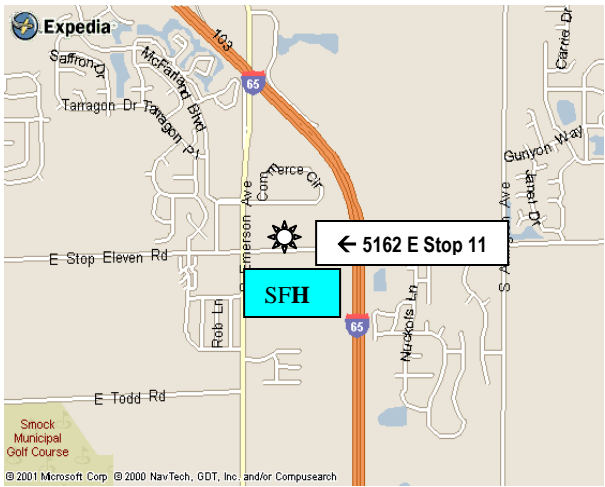
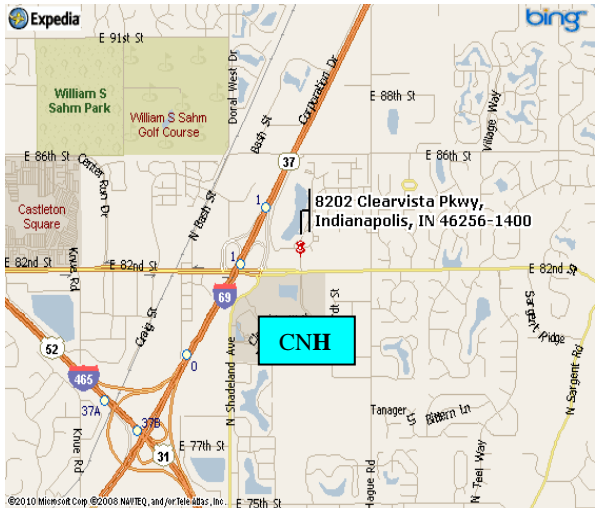
Maps for Allergy Associates

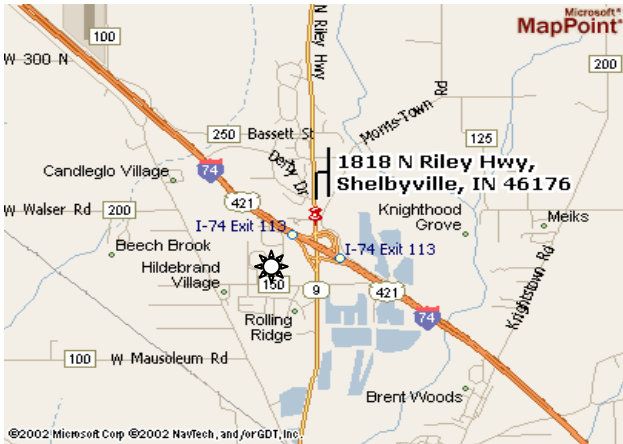
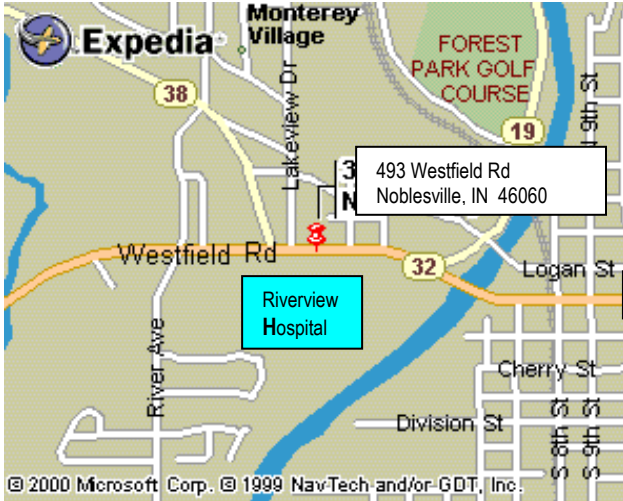
3266 N. Meridian (317) 924-8297
 Voice Mail 24 hr (317) 924-8295
 Fax (317) 924-8239
 Toll Free (800) 358-3944
 8202 Clearvista (317) 621-5460
 Noblesville office (317) 621-5460
 1303 N. Arlington (317) 356-1004
 5162 E. Stop 11 (317) 859-9003
 8803 N. Meridian (317) 848-4070
 Avon office (317) 272-8095
 Shelbyville office (317) 398-3832
 Greensburg office (800) 358-3944
 Muncie office (765) 289-2575



Also a Muncie office further north

Also a Greensburg office further south





“Ancillary Information”

Below are the answers to some of the frequently asked questions about our practice. For further explanations please feel free to call **924-8297, ext 602** and discuss your situation with me, the practice manager.

“Common Questions”

Telephone calls:

All telephone calls are returned. If you do not receive a return call in twenty-four hours, then please call again as a wrong number may be recorded or the physician or staff may call when you are unavailable. Always leave a work and home phone number.

Some situations are Emergency situations. If you feel our response has not been timely enough for your particular difficulty, call back and reinforce to the nurse or receptionist your EXACT problem. Most phone calls are returned within several hours so we can discuss your difficulty uninterrupted. For an appropriate response time please leave a brief message with the receptionist or on the voice mail system for the best time to return your call.

For emergency situations, there is always a physician ‘On Call’ for your doctor. Keep in mind, however, that the covering physician does not have your medical chart so you will be required to know the names of your medications and dosages.

This is always a good practice for situations where you may require Emergency Room medical care. We have Medication Cards available for you to record your medications. Please request a card from one of our staff members.

However, you can leave a general message for the nurse or physician 24 hours per day, 7 days a week by dialing **924-8295**. Your call will be returned the next business day.

Medication refills:

Please allow **twenty-four hours** for routine refills. You can request medication refills 24 hours per day, seven days per week by dialing 924-8295 and following the instructions. The medication refill may be called in the next business day if your physician approves the medication.

If you do call in after hours or on weekends, the medication refill will be limited to only a few days. Some medications are not automatically refilled, so leave your home and work phone number. To avoid pharmacy errors, it is best if you leave the name of the drug, the refill number, and the dosage. Since there are many pharmacies, we **DO NOT** look up pharmacy phone numbers for you. Please, have this available before you call.

For all routine refills, you must see your allergist at least one time within the last 12 months.

Appointments:

An attempt will be made to confirm your appointment. If you do not get a reminder call the business day before, you may want to call and verify your appointment. Ill patients are seen on a fill-in basis, but you must contact the office and get a general time you can be seen. Walk-in appointments are discouraged.

If you cannot keep your appointment, please notify us 36 hours ahead of time. We reserve the right to bill you for failed appointments.

Fees and Insurance:

Allergy Associates uses Memorial Clinic of Indianapolis to process billing. We do file insurance for you at no extra charge for claims over \$28.00. However, we do require correct addresses, policy numbers, names of insured, and in some cases, insurance forms. Please bring these with you at the time of the first visit and any time your insurance changes. In most cases, a signature is required by the policyholder before we can file any insurance.

For traditional insurance we generally require 20% payment of the total bill at the time of service. If you require a deviation from this policy, please call (317) 924-8228 before the appointment to discuss your particular situation with the

office manager. Also, it is always sound policy for you to check with your insurance company to see if you are covered for your planned visit to the Allergist. (Please read attached page for the Memorial Clinic of Indianapolis Policy)

Generally, most insurance companies respond to an insurance claim in 45 days. If you do not receive a response from the insurance company within that period of time please call 924-8280 to inquire if the insurance has been filed. If it has, then contact your insurance company.

After the insurance company has responded to your claim, please begin payment as soon as possible on any remaining balance. If the total amount is over the amount you can pay in one month's time, please call 924-8228 to set-up a payment plan. Generally, the physicians require regular monthly payments so the accounts are paid in full within three months. Please check with them if you need to deviate from this schedule.

Members of Health Maintenance Organizations (HMO) are generally required to have a referral before seeing an allergist. Please hand-carry the referral form with you at the time of your visit so you and your physician know the visit is authorized. You are responsible for requesting the initial referral from your primary care physician. The referral can be faxed to 924-8270. **Co-payments are required at the time of the visit.**

Members of Preferred Provider Organizations (PPO) may require a referral for allergy testing. Please contact your insurance company prior to your appointment. Also, some types of PPO insurance do contain a deductible and a co-payment. We will collect the co-payment at the time of your appointment and bill you for the deductible after your insurance has notified us of your responsibility.

Quality Assurance

I encourage you as a consumer to contact me about any major complaints or problems with other staff members. At times miscommunications can occur. If there is a problem, please feel free to contact me at your convenience so a resolution to your difficulty can be attempted.

You can reach me by dialing the (317) 924-8295, ext 602 to leave me a private, detailed message so I can return your call. If I am unavailable, leave the best time to return your call.

If we did not cover all of your questions, please contact the office in writing or by phone.

Rebecca Goldberg, RN
Practice Manager

Allergy Associates of Central IN, LLC
Identity theft prevention and detection and Red Flags Rule compliance

Policy

It is the policy of Allergy Associates of Central IN, LLC to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how Allergy Associates of Central IN, LLC will (1) identify, (2) detect and (3) respond to “red flags.” A “red flag” as defined by this policy includes a pattern, practice, or specific account or record activity that indicates possible identity theft.

It is the policy of Allergy Associates of Central IN, LLC that this Identity theft prevention and detection and Red Flags Rule compliance program is approved by Allergy Associates of Central IN, LLC as of August 1, 2009, and that the policy is reviewed and approved no less than annually.

It is the policy of Allergy Associates of Central IN, LLC that Rebecca A. Goldberg, Executive Director is assigned the responsibility of implementing and maintaining the Red Flags Rule requirements. Furthermore, it is the policy of this Allergy Associates of Central IN, LLC that this individual will be provided sufficient resources and authority to fulfill these responsibilities. At a minimum, it is the policy of Allergy Associates of Central IN, LLC that there will be one individual or job description designated as the privacy official.

It is the policy of Allergy Associates of Central IN, LLC that, pursuant to the existing HIPAA Security Rule, appropriate physical, administrative and technical safeguards will be in place to reasonably safeguard protected health information and sensitive information related to patient identity from any intentional or unintentional use or disclosure.

It is the policy of Allergy Associates of Central IN, LLC that its business associates must be contractually bound to protect sensitive patient information to the same degree as set forth in this policy. It is also the policy of this Allergy Associates of Central IN, LLC that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

It is the policy of Allergy Associates of Central IN, LLC that all members of our workforce have been trained by the August 1, 2009 compliance date on the policies and procedures governing compliance with the Red Flags Rule. It is also the policy of Allergy Associates of Central IN, LLC that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of Allergy Associates of Central IN, LLC to provide training should any policy or procedure related to the Red Flags Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of Allergy Associates of Central IN, LLC that training will be documented, indicating participants, date and subject matter.

Procedures

I. Identify red flags. In the course of caring for patients, Allergy Associates of Central IN, LLC may encounter inconsistent or suspicious documents, information or activity that may signal identity theft. Allergy Associates of Central IN, LLC identifies the following as potential red flags, and this policy includes procedures describing how to detect and respond to these red flags below:

1. A complaint or question from a patient based on the patient’s receipt of:
 - A bill for another individual;
 - A bill for a product or service that the patient denies receiving;
 - A bill from a health care provider that the patient never patronized; or
 - A notice of insurance benefits (or explanation of benefits) for health care services never received.
2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient.
3. A complaint or question from a patient about the receipt of a collection notice from a bill collector.
4. A patient or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
5. A complaint or question from a patient about information added to a credit report by a health care provider or health insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.

II. Detect red flags. Allergy Associates of Central IN, LLC practice staff will be alert for discrepancies in documents and patient information that suggest risk of identity theft or fraud. Allergy Associates of Central IN, LLC will verify patient identity, address and insurance coverage at the time of patient registration/check-in.

Procedure:

1. When a patient calls to request an appointment, the patient will be asked to bring the following at the time of the appointment:
 - Driver’s license or other photo ID;

- Current health insurance card; and
 - Utility bills or other correspondence showing current residence if the photo ID does not show the patient's current address. If the patient is a minor, the patient's parent or guardian should bring the information listed above.
2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above.
 3. The patient will be asked at each visit to verify address and other demographic information and sign the appropriate form.
 - If the information is correct, the patient or adult with the minor patients will sign the appropriate form to verify the information is correct
 - If any changes are required, the patient or adult with the minor patient will write the corrections on the appropriate form and then sign that the changes are appropriate
 4. Staff should be alert for the possibility of identity theft in the following situations:
 - The photograph on a driver's license or other photo ID submitted by the patient does not resemble the patient.
 - The patient submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
 - Information on one form of identification the patient submitted is inconsistent with information on another form of identification or with information already in the practice's records.
 - An address or telephone number is discovered to be incorrect, non-existent or fictitious.
 - The patient fails to provide identifying information or documents.
 - The patient's signature does not match a signature in the practice's records.
 - The Social Security number or other identifying information the patient provided is the same as identifying information in the practice's records provided by another individual, or the Social Security number is invalid.

III. Respond to Red Flags. If an employee of Allergy Associates of Central IN, LLC detects fraudulent activity or if a patient claims to be a victim of identity theft, Allergy Associates of Central IN, LLC will respond to and investigate the situation. If the fraudulent activity involves protected health information (PHI) covered under the HIPAA security standards, Allergy Associates of Central IN, LLC will also apply its existing HIPAA security policies and procedures to the response.

Procedure

If potentially fraudulent activity (a red flag) is detected by an employee of Allergy Associates of Central IN, LLC:

1. The employee should gather all documentation and report the incident to his or her immediate supervisor or designated compliance officer/privacy official, Rebecca A. Goldberg, Executive Director.
2. The supervisor or designated compliance officer/privacy official, Rebecca A. Goldberg, Executive Director will determine whether the activity is fraudulent or authentic.
3. If the activity is determined to be fraudulent, then Allergy Associates of Central IN, LLC should take immediate action. Actions may include:
 - Cancel the transaction;
 - Notify appropriate law enforcement;
 - Notify the affected patient;
 - Notify affected physician(s); and
 - Assess impact to practice.

If a patient claims to be a victim of identity theft:

1. The patient should be encouraged to file a police report for identity theft if he/she has not done so already.
2. The patient should be encouraged to complete the ID Theft Affidavit developed by the FTC, along with supporting documentation.
3. Allergy Associates of Central IN, LLC will compare the patient's documentation with personal information in the practice's records.
4. If following investigation, it appears that the patient has been a victim of identity theft, Allergy Associates of Central IN, LLC will promptly consider what further remedial act/notifications may be needed under the circumstances.
5. The physician will review the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, a notation should be made in the record to indicate identity theft.
6. The practice medical records staff will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken. The patient is responsible for contacting ancillary service providers.
7. If following investigation, it does not appear that the patient has been a victim of identity theft, Allergy Associates of Central IN, LLC will take whatever action it deems appropriate.

PROFESSIONAL ASSOCIATES, PC

Billing & Administration Offices

3266 North Meridian Street, 9th Floor

P.O. Box 88380

Indianapolis, Indiana 46208

PAYMENT POLICY

We are committed to providing you with the best possible medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates with a variety of insurance plans. **IT IS YOUR RESPONSIBILITY TO:**

- **Be prepared to pay your co pay at each visit.**
- **Payment can be made by cash, check or credit card (Visa or Master Card).**
- **Bring your insurance card to every visit.**
- **Inform us if your insurance changes.**
- **Inform us if you have a new home address or phone number.**
- **REFERRALS: Bring any required referrals for services at or prior to your scheduled visit. If our office has not received your referral prior to your office visit, you will have the option to reschedule your visit, or you may sign a non-referral form and accept financial responsibility for the services rendered. Payment will be due at the time of visit.**
- **Non-Covered Services: For medical care not covered under your insurance plan, payment in full is due at the time of visit.**

NON-PARTICIPATION - If you have insurance that we do not participate in, our office is happy to file the claim upon request; **however, payment in full is expected at the time of visit.**

SELF PAY PATIENTS - If you do not have insurance, you are expected to pay for professional services at the time of visit. If you are unable to pay for necessary medical care, you should inform our receptionist and contact our Billing Office at (317) 924-8284 to make payment arrangements.

HMO PATIENTS - Our office staff is committed to assisting you obtain a referral from your Primary Care Physician's office but it is your responsibility to verify that we have a valid referral on file prior to your visit.

INSURANCE COVERAGE - If you have questions about your insurance, our billing department is happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department. Please refer to the number on your insurance card.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about your account or establishing financial arrangements should be addressed with our Billing Department by calling (317) 924-6131.

Thank you for your assistance.

NEW PATIENT MEDICATION CHECK LIST **(for SKIN TEST appt)**

****There are many different allergy medications, if you are taking something that is not on this list and you are not sure please call the office at 317-924-8297 or 800-358-3944.**

1. **Stop prescription antihistamines 7 days prior to appointment:**

Claritin – Claritin D (Loratadine)
Clarinex
Allegra – Allegra D (Fexofenadine)
Zyrtec – Zyrtec D (Cetirizine)
Atarax (Hydroxyzine HCL)
Doxepin
Vistaril
Periactin
Phenergan (Promethazine)
Xyzal
Astelin nasal spray
Patanase nasal spray
Astepro
Antivert
Amitriptyline (Elavil)

2. **Stop over-the-counter antihistamines and prescription eye drops 3 days prior to the appointment:**

Sudafed (Pseudoephedrine)	Cough Medicines (OTC)
Benadryl (Diphenhydramine)	Naphcon-A eye drop (OTC)
Chlor-Trimeton (Chlorpheniramine)	Optron-A eye drop (OTC)
Tussionex	Visine (OTC)
Patanol eye drop	Elestat eye drop
Optivar eye drop	Pataday eye drop
Livostin eye drop	
Alomide eye drop	
Any meds with <u>P.M.</u> after it	

3. Prednisone should not be taken the day of the appointment.
4. Nasal sprays (except Astelin, Astepro, Patanase) are okay to continue.
5. Asthma medications, including Singulair, should be continued.

For staff use only) Date: _____ Pt Number: _____ Physician: _____ Referring Physician: _____

**ALLERGY, ASTHMA & CLINICAL
IMMUNOLOGY ASSOCIATES
ALLERGY ASSOCIATES OF CENTRAL INDIANA**

Diplomates of The American Board of Allergy and Immunology
(A Conjoint Board of The American Boards of Internal Medicine and Pediatrics)
Pinkus Goldberg, M.D. Douglas J. Horton, M.D. Steven L. Wise, M.D.

Patient Questionnaire

Name: _____

*Doctors Notes (Do Not Write Here)
History of Present Illness*

Chief Complaint: Briefly explain the major reason you are here to see us and how long this has been a difficulty.

Symptoms: (Please Check)

Eyes and Ears: _____ Itchy & watery eyes _____ Red eyes
_____ Swelling about eyes _____ Light hurts eyes
_____ Ear infections _____ Decreased hearing

Nose: _____ Stuffy _____ Itchy
_____ Runny _____ Sneezing
_____ Decreased smell _____ Postnasal drainage
_____ Nosebleeds _____ Nasal polyps
_____ Frequent colds _____ Nose spray use
_____ Sinus headaches

Throat: _____ Sore throat _____ Infections _____ Tonsillitis

Lungs: _____ Wheezing _____ Coughing _____ Bronchitis
_____ Pneumonia _____ Frequent respiratory infections
_____ Shortness of breath _____ Tightness in chest
_____ Pneumonia _____ Coughing blood
_____ Pleurisy _____ TB (Tuberculosis)

Skin: _____ Hives _____ Eczema _____ Rashes
_____ Itching _____ Sores

Variation of Symptoms: (Please check)

Are your symptoms

_____ Worse in any seasons:(spring, summer, fall, winter, same year round)
_____ Worse during specific times of the day: (morning, evening, bed, no change)
_____ Worse when : _____inside _____outside
_____ Different on weekends: _____ better _____ worse _____ no change
_____ Worse with: _____ exercise, _____ hobbies, _____ at work
_____ Ever required the use of cortisone (steroids, Prednisone, Medrol, Decadron, Aristocort) Reason used _____
_____ Emergency Room Visit _____ Asthma _____ Other
State Reason:

Precipitating Factors: Circle each of the following which you have noticed make your symptoms worse:

- House dust Insect spray Temperature change
- Wool Paint Enzyme detergents
- Turning mattress Perfumes Aspirin
- Feathers Hair spray Newsprint
- Flowers Cigarette smoke Antihistamines
- Raking leaves Deodorants Fatigue
- Mowing grass Air pollution Tension
- Hay or Straw Fertilizers Cough
- Barn dust Christmas trees Menstruation
- Dampness Emotional upsets Birds
- Basements Exertion Dogs
- Cottages or cabins Heat Cats
- Colds Cold air Horses
- Respiratory infections Wind Other animals
- Other

Past Medical History: (Please check)

Have you had any allergic reactions or any type of bad reactions to any medications? Yes No

If so, which ones? _____

Do any foods or beverages bother you (i.e., cause asthma, cramps, rash)?

Yes No

Explain: _____

Do you now, or did you ever, smoke? Yes No

If yes, what and how much per day? _____

How many years? _____

Do members of your household smoke? _____

Have you had any adverse reactions to a bee, wasp or yellow jacket sting?

Yes No

If so what type _____

Latex Sensitivities _____

Medical Illnesses: List any medical illnesses not included above (i.e., hypertension, diabetes, heart disease, arthritis)

Surgeries: Please List

Chest X-ray (Yes/No)	Sinus X-ray (Yes/No)
Location _____	Location _____
Date _____	Date _____

Previous Hospitalizations: *Please list all*

Date Hospital Diagnosis/Treatment

Medication List:

Name Dose Times per Day

Past Allergy and Asthma Medications:

Environmental History: Check or fill in blank

Residence:

Type: ___ House ___ Apartment ___ Other

How old is your present home? _____

In what area is your present home located?

___ Urban ___ Rural ___ Suburban

___ Industrial ___ Heavily Wooded

Heating System:

Type: ___ Steam ___ Hot water

 ___ Forced air ___ Space heater

 ___ Electric radiant coils

Air Conditioning: ___ None ___ Central ___ Room

Humidifiers: ___ None ___ Central ___ Portable

Basement: ___ Yes ___ No

Does your basement smell musty? ___ Yes ___ No

Bedrooms: How many beds in room where patient sleeps?

Mattresses type: ___ Innerspring ___ Cotton Felt ___ Foam

Pillows: ___ Foam ___ Dacron

 ___ Feather ___ Cotton

Do you have any of the following in your bedroom:

___ Stuffed toys ___ Upholstered furniture ___ Pets

Bed Covers: ___ Cotton spreads ___ Quilt/comforter ___ Wool blanket

Flooring: ___ Wall to wall carpeting ___ Hardwood ___ Linoleum/vinyl

Pets: ___ Dog ___ Cat ___ Bird

 ___ Horse Other _____

Doctors Notes (Do Not Write Here)

Family History:

Doctors Notes (Do Not Write Here)

	<i>Asthma</i>	<i>Hay Fever</i>	<i>Eczema</i>	<i>Hives</i>	<i>Sinus Problem</i>
<i>Mother</i>					
<i>Father</i>					
<i>Brother</i>					
<i>Sister</i>					
<i>Children</i>					
<i>Aunt</i>					
<i>Uncle</i>					
<i>Grand-father</i>					
<i>Grand-mother</i>					

Do any relatives have:

- Heart disease Emphysema
 Diabetes High blood pressure
 Other

Social History:

Line of work? _____

If a child, involvement with day care:

Full time after school part time

Have you ever worked around:

- Asbestos Plastics/acrylics
 Moldy hay or grain Pigeons or parakeets
 Steel mill Beryllium
 Sand blasting Welding arc
 Detergent factory Meat wrappers
 Sugar cane fields A mine or quarry

Recent travel to a foreign country Yes No

If so where and when:

Marital Status: Married Divorced
 Single Widowed

Children: _____

How much alcohol do you drink? Per day _____ Per week _____

Recreational drug use (Cocaine, marijuana, other)?

Review of Systems: (Please check symptoms you have)

Doctors Notes (Do Not Write Here)

General: (Constitutional) General health is:

_____ Good _____ Fair _____ Poor

Recent Weight loss _____ Weight gain _____ Fevers _____

Eyes: _____ Glaucoma _____ Glasses
_____ Visually Impaired _____ Legally Blind

Head/Neck: _____ Migraine headaches _____ Nosebleeds
_____ Odor of breath _____ Hoarseness
_____ Ringing in ears _____ Broken nose
_____ Hearing Impaired _____ Severity

Cardiovascular: _____ Heart murmur _____ Palpitations
_____ Swelling of legs _____ Chest pain
_____ Heart attack _____ Angina
_____ Blood clots _____ Easy bruising
(Thrombophlebitis)

Gastrointestinal:

_____ Stomach ulcers _____ Difficulty swallowing
_____ Irritable bowel _____ Abdominal pain
_____ Blood in stool _____ Vomit blood
_____ Yellow jaundice _____ Hepatitis
_____ Pancreatitis _____ Constipation
_____ Diarrhea _____ Gall Bladder Problems
_____ Heart Burn

Genitourinary: _____ Difficulty urinating _____ Bladder infections
_____ Yeast infections _____ Kidney infections
_____ Kidney stones _____ Blood in urine
_____ Painful urination _____ Incontinence
_____ Menstrual abnormalities

Hematological/Oncological/Lymphatic:

_____ Swelling of lymph glands Where:
_____ Anemia _____ Blood disease Type:
_____ Cancer Type: _____ Remission (Yes/No)

Musculoskeletal/Rheumatologic:

_____ Joint pain _____ Back pain
_____ Rheumatoid arthritis _____ Gout
_____ Herniated disk _____ Osteoporosis
_____ Fibromyalgia _____ Lupus

Endocrine: _____ Heat intolerance _____ Diabetes
_____ Thyroid disease

Neurologic: _____ Dizziness _____ Stroke
_____ Vertigo (room spins) _____ Numbness
_____ Tingling _____ Bell's palsy
_____ Weakness of an extremity

Psychiatric: _____ Nervousness _____ Anxiety _____ Depression
_____ Considered or Attempted Suicide
_____ Drug abuse _____ Current _____ Past
Other disorders _____

Infections: _____ Up to date with immunizations
_____ Recurrent Infections, Location
_____ Pneumovax _____ Flu Vaccination