# Southwest Allergy & Asthma Associates, P.A.

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11410 Vista Del Sol, El Paso, TX, 79936, (915)592-6269

Find this handout and other educational information at **www.elpasoallergy.com**

Last Name:_____ First Name:_____

Date: _____ Birthdate:_____

Referring Doctor:_____ Referring Patient:_____

**ARE YOU HERE FOR** (please circle all that apply)

ALLERGIES ASTHMA CHRONIC INFECTIONS, URTICARIA/HIVES, ECZEMA, DRUG ALLERGY, INSECT ALLERGY

**MAIN SYMPTOMS THAT AFFECT YOU:**

_____

Date symptom(s) began:_____

**ALLERGIC AND CHRONIC INFECTION SYMPTOMS** (check all that apply)

**Nasal**:
- ☐ Bloody nose
- ☐ Clear runny nose
- ☐ Discolored mucus
- ☐ Itching
- ☐ Loss of smell
- ☐ Nasal polyps
- ☐ Rubbing
- ☐ Sneezing
- ☐ Congestion

**Sinus:** ☐ Headache
- ☐ Above eyes
- ☐ Below eyes
- ☐ Temples

☐ Bad Breath
☐ Snoring
☐ Stop breathing when you snore
☐ History of broken nose

**Eyes:** ☐ Itching
- ☐ Watery
- ☐ Redness
- ☐ Swelling
- ☐ Blurry vision

**Ears:** ☐ Dizziness
- ☐ Ear pain
- ☐ Chronic infections
- ☐ Popping
- ☐ Do you have ear tubes?

**Throat:** ☐ Hoarseness
- ☐ Postnasal drainage
- ☐ Throat clearing
- ☐ Sore throat

**Breathing:** ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Past chest X-Ray? When?_____

**Asthma history:**
- ☐ Symptoms only at work
- ☐ Symptoms with infections

Symptoms with exercise
- ☐ Nighttime symptoms
- ☐ Recent albuterol use
- ☐ Have you been hospitalized for asthma?
- ☐ Do you have a peak flow meter?
- ☐ Do you use a spacer?

**Chronic infections:**
- ☐ Recurrent fevers
- ☐ Frequent ear infections
- ☐ History of pneumonia?
- ☐ History of bronchiolitis or bronchitis?
- ☐ History of life threatening infections?
- ☐ Frequent strep throat

**THESE SYMPTOMS OCCUR MOSTLY DURING THE:**

☐ Spring ☐ Summer ☐ Fall ☐ Winter

☐ Daytime ☐ Night ☐ Indoors ☐ Outdoors

**SYMPTOMS ARE WORSENED BY:**

☐ Air conditioning ☐ Cutting grass ☐ Dust ☐ Raking leaves

☐ Cat exposure ☐ Detergent odor ☐ Exercise ☐ Stress

☐ Cigarette smoke ☐ Dog exposure ☐ Perfume ☐ Strong odors

**DO YOU HAVE THESE IN YOUR HOME OR AT WORK:**

☐ Indoor cats ☐ Indoor dogs ☐ Feather pillow

☐ Outdoor cats ☐ Outside dogs ☐ Down comforter

☐ Birds ☐ Hamsters, gerbils or rabbits ☐ Secondhand smoke

**PAST ALLERGY TESTING AND TREATMENT:**

Past allergy testing: Where? _____ When? _____

Past allergy shots: Where? _____ When? _____

Did you have any reactions to the allergy shots? _____

Did the shots help? ☐ Yes ☐ No ☐ Somewhat

☐ Nasal surgery? Please describe:_____ Surgeons name:_____

**FOOD ALLERGIES**:

☐ Peanuts ☐ Shortness of breath

☐ Nuts ☐ Hives

☐ Seafood ☐ Itching

☐ Eggs ☐ Throat closing

☐ Milk ☐ Other symptoms _____

☐ Other foods _____ ☐ Were your symptoms immediately after eating?

☐ Do fresh fruits cause itching of your mouth? ☐ Do you have an EpiPen?

**SKIN RASHES:**

Do you have? ☐ Hives ☐ Eczema ☐ Molluscum ☐ Other rash? _____

Where is your rash? _____

What do you think is causing your rash? _____

**Is your rash**: ☐ Itchy ☐ Painful ☐ Burning ☐ Scaly ☐ Cracking ☐ Oozing

**How long does your rash last?** ☐ Minutes ☐ Hours ☐ Days

**When is your rash worse?** ☐ Morning ☐ Daytime ☐ Night

Any new foods since the rash started? ☐ No ☐ Yes_____

Any new medications since the rash started? ☐ No ☐ Yes _____

Does anyone in your family have swelling? ☐ Yes ☐ No Have you ever had hives before? ☐ Yes ☐ No

Have you had easy bruising? ☐ Yes ☐ No Do any foods make your rash worse? ☐ Yes ☐ No

**Is your rash worsened by the following:**

☐ Soaps ☐ Perfumes ☐ Pressure ☐ Stress ☐ Water ☐ Heat ☐ Cold

☐ Contact with Latex ☐ Contact with metals ☐ Contact with plastics ☐ Contact with dyes

**SKIN CARE:**

What laundry detergent do you use? _____

What soap do you use for bathing? _____

What lotion do you use? _____

**DRUG ALLERGIES:**

Medication: _____ What symptoms?_____

Medication: _____ What symptoms?_____

Medication: _____ What symptoms?_____

**MEDICAL HISTORY:**

Medical Problems: _____

Do you have: □ Diabetes □High Blood Pressure □ Glaucoma □ Osteoporosis

Surgeries: _____

Do you take herbal medications or supplements? □ Which? _____

**CURRENT MEDICATIONS:** (Continue on back if necessary)

| Medication Name: | Dosage: | When Used: | When Started: | Reason for use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| **FAMILY HISTORY:** | Allergies | Asthma | Hives | Eczema | Sinusitis |
|---|---|---|---|---|---|
| Parents: | □ | □ | □ | □ | □ |
| Children: | □ | □ | □ | □ | □ |

**SOCIAL HISTORY:**

Do you smoke? □ Yes How long? _____ When did you quit? _____

Do you drink excessive amounts of alcohol? □ Yes Are you exposed to any chemicals at work or home? □ Yes

Where do you work? _____ Do you work outside? □ Yes

**DO YOU HAVE ANY OF THESE SYMPTOMS:**

| | | | |
|---|---|---|---|
| □ Fatigue | □ Chills | □ Loss of appetite | □ Weight loss |
| □ Chest pain | □ Leg swelling | □ Palpitations | □ Swollen lymph nodes |
| □ Cold intolerance | □ Hair loss | □ Night sweats | □ Thyroid problems |
| □ Belly pain | □ Diarrhea | □ Constipation | □ Heartburn |
| □ Anemia | □ Easy bruising | □ Dizziness | □ Blurry vision |
| □ Blood in the urine | □ Slow urine flow | □ Insomnia | □ Anxiety |
| □ Arthritis | □ Bone pain | □ Joint pains | □ Leg muscle cramps |

**PREVIOUSLY USED MEDICATIONS**

**ANTIHISTAMINES:**

- ☐ Allegra/Fexofenadine
- ☐ Allegra-D
- ☐ Claritin/Loratadine
- ☐ Claritin-D
- ☐ Hydroxyzine
- ☐ Palgic/Carbinoxamine
- ☐ Zyrtec/Cetirizine
- ☐ Zyrtec-D
- ☐ Xyzal/levocetirizine

**ASTHMA MEDICATIONS**

- ☐ Advair
- ☐ Alvesco
- ☐ Asmanex
- ☐ Azmacort
- ☐ Breo
- ☐ Dulera
- ☐ Flovent
- ☐ Pulmicort
- ☐ Qvar
- ☐ Serevent
- ☐ Singulair
- ☐ Spiriva
- ☐ Symbicort
- ☐ Xolair

**NASAL SPRAYS:**

- ☐ Astelin
- ☐ Flonase
- ☐ Fluticasone
- ☐ Dymista
- ☐ Nasacort AQ
- ☐ Nasonex
- ☐ QNasl
- ☐ Patanase
- ☐ Rhinocort AQ
- ☐ Veramyst
- ☐ Zetonna

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### HIPAA Notice of Privacy Practices

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The HIPAA Notice of Privacy Practices describes how we may use and disclose your protected health information. It also describes your rights to access and control your protected health information.

This information is located on the main page of our website www.elpasoallergy.com or you may ask for a copy of our HIPAA Notice of Privacy Practices at our front desk.

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. If you have any objections to our HIPAA Notice of Privacy Practices, please ask to speak with our HIPAA Privacy Official (Nora McCullen, Privacy Official) in person or by phone at (915) 592-6269.

Your signature below only acknowledges that you received a paper copy of our HIPAA Notice of Privacy Practices.

Signature: _____Date:_____

Relationship: (If not signed by patient): _____

### APPOINTMENT CANCELLATION POLICY

Our office sees patients by appointments only. Every effort will be made to provide the earliest possible attention for the convenience of the patient. As we are often overbooked for more than a month no shows prolong the amount of time it can take to see other patients.

A **$25.00 fee** will be charged to you if you fail to notify the office within 24 hours of cancellation of your appointment.

Due to the unscheduled nature of emergencies, we will allow one emergency per year without charge to the patient if you fail to notify us and do not arrive for your appointment.

Please notify us as early as possible so that we are able to offer the time to another patient who will be grateful for your thoughtfulness.

I have been presented with a copy of the cancellation policy, explaining how failure to cancel my appointment within 24 hours will result in a fee charged to my account.

Signature: _____Date:_____

Relationship: (If not signed by patient): _____

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**PLEASE PRINT • FILL OUT COMPLETELY** **Date** _____

**PATIENT INFORMATION**

Name _____ Date of Birth _____ Social Security # _____

Home Phone _____Cell Phone: _____Marital Status: Single_____Married_____

Address _____City _____ State _____Zip code _____

Patient's Employer _____ Work Phone _____

Employers Address _____City _____ State _____Zip code _____

Nearest Relative or Friend _____Relationship _____
(**NOT LIVING IN SAME HOUSEHOLD**)
Address _____Home Phone _____

**INSURANCE INFORMATION**

Name of Insurance _____Phone #_____

Group # _____Insurance ID # _____Date of Birth _____

Name of Policyholder _____Address _____

Name of Employer _____Relationship to Patient _____

**RESPONSIBLE PARTY IF A MINOR OR SPOUSE INFORMATION**

Name _____Date of Birth _____

Address _____Home Phone _____

City _____State _____Zip code _____Social Security # _____

Employer Name _____Marital Status: Single_____Married_____

Work Phone _____Cell Phone#: _____

Email Address _____

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## COORDINATION OF BENEFITS

**All professional services are charged to the patient. The patient is responsible for charges rendered at the time of service which include co pays, coinsurance and deductibles. There are no exceptions unless prior arrangements have been made.**

**Please READ and SIGN the following authorization for treatment and assignment of benefits.**

**It is your responsibility as the patient or guardian of patient, to update this office with new insurance information as soon as the effective date is known. If new insurance information is not presented in a timely manner then you will be responsible for any and all charges incurred after effective date of new insurance coverage. All insurance companies have a timely filing deadline and if claim is not received before filing deadline then claim will deny and become your responsibility. There will be a fee of $25.00 for failure to notify us and your insurance carriers of any changes.**

**If you should have any questions you may speak to the insurance clerk.**

**I hereby authorize Southwest Allergy and Asthma Associates, PA to furnish information to insurance carriers concerning my illnesses and treatments, and I hereby assign to the doctor all payments for medical service rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and equally liable if my insurance carrier does not pay for service within period of (9) weeks.**

_____ _____

**Patient or Responsible Party Signature** **Date**

_____

**Print Name**