

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 WORSENERD 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
- Nuts
- Seafood
- Eggs
- Milk
- Other foods _____
- Do fresh fruits cause itching of your mouth?
- Shortness of breath
- Hives
- Itching
- Throat closing
- Other symptoms _____
- Were your symptoms immediately after eating?
- 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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