Patient Name: _____Chart #: _____ Date:_____

The Allergy, Asthma & Sinus Center

New Patient Questionnaire

PATIENT NAME: _____

AGE: _____ **DOB:** _____ **REFERRING PROVIDER (If any):** _____

GENDER: ( ) Male ( ) Female **MARITAL STATUS:** ( ) Single ( ) Married ( ) Divorced ( ) Widowed

RACE OR ETHNIC GROUP: ( ) American Indian or Alaskan Native ( ) Asian or Pacific Islander ( ) Black
(For medical use only) ( ) Hispanic/Latino ( ) White ( ) I decline to respond
Multi-race individuals may check all that apply

PHARMACY: (Please list pharmacy name and location) _____

CHIEF COMPLAINT: (Please briefly describe your symptoms in the space provided below)

_____

_____

ALLERGIC HISTORY: Please mark any that apply to you. This information is so that we can understand why you came to see us.

NOSE

Itchy Nose _____
Sneezing _____
Runny Nose _____
Stuffy Nose _____
Coryza _____
Decreased Smell _____
Post Nasal Drainage _____
Headache _____
Sinus Infection _____

THROAT

Sore Throat _____
Hoarseness _____

EYES

Itchy eyes _____
Red eyes _____
Watery eyes _____

EARS

Itchy ears _____
Blocked ears _____

COUGH

Chest cough _____

CHEST

Wheeze _____
Shortness of breath _____
Tightness in chest _____

SKIN

Hives _____
Rash _____
Eczema _____
Itching _____
Swelling _____

GASTROINTESTINAL

Heartburn _____
Reflux _____

HEADACHE: Do you have headaches associated with your nasal & sinus symptoms? ( ) Yes ( ) No
Do you have a history of migraines? ( ) Yes ( ) No

INSECT STING:
Have you ever had a severe reaction to a bee sting? ( ) Yes ( ) No
If yes, please explain: _____
Have you ever had a severe reaction to a fire ant sting? ( ) Yes ( ) No
If yes, please explain: _____

FOODS: Please describe any food reactions/sensitivities. _____
_____

LATEX: Do you have exposure to latex (rubber) products on a regular basis? ( ) Yes ( ) No
Has latex exposure at a medical or dental office caused nasal/lung symptoms or hives/excessive swelling? ( ) Yes ( ) No

FOR OFFICE USE ONLY:

_____ _____
Provider Signature Date

Patient Name: _____Chart #: _____ Date:_____

IMMUNIZATIONS:

Have you been vaccinated against pneumonia? ( ) Yes ( ) No If yes, when: _____
Have you been vaccinated for chicken pox? ( ) Yes ( ) No If yes, when: _____
Or have you had chicken pox? ( ) Yes ( ) No If yes, when: _____
Have you had a flu shot this year? ( ) Yes ( ) No If yes, when: _____
Are childhood immunizations up to date? ( ) Yes ( ) No

ALLERGY SURVEY:

Please mark any factors that cause an increase in your symptoms:

ALLERGENS

Mowed grass _____
House Dust _____
Cats _____
Dogs _____
Moldy/musty places _____
Hay/dead leaves _____
Pollen _____

IRRITANTS

Smoke _____
Outside dust _____
Odors _____
Paint _____
Perfumes _____
Fumes _____
Hair spray _____
Soaps _____
Detergents _____

WEATHER CHANGES

Windy days _____
Cold Fronts _____
Temperature Changes _____
Damp Weather _____

Do you experience allergy symptoms seasonally or year round? ( ) Seasonally ( ) Year round
If seasonally, please mark all that apply: ( ) Spring ( ) Summer ( ) Fall/Autumn ( ) Winter
What type of heating/cooling system do you have?
Forced Air (central) _____ Radiant _____ Wood _____ Kerosene/Oil _____ Ceiling Fan _____
Do you use any feather products on your bed? ( ) Yes ( ) No
Do you sleep with stuffed animals? ( ) Yes ( ) No
Do you have carpet in your bedroom? ( ) Yes ( ) No
Do you have pets? ( ) Yes ( ) No
If yes, what kind?Indoor _____
Outdoor _____
Do your pets sleep with you? ( ) Yes ( ) No

REVIEW OF SYSTEMS:

Please mark any that apply to you. This information is so that we can better understand your general health and well-being.

GENERAL

Appetite change _____
Weight change _____
Fatigue _____
Fever _____
Chills _____
Sweats _____

CARDIOVASCULAR

Chest pain _____
Palpitations _____

GENITOURINARY

Urinary difficulty _____

MUSCULOSKELETAL

Joint pain _____
Joint swelling _____
Muscle pain _____
Weakness _____
Backache _____

NEUROLOGICAL

Dizziness _____

PSYCHIATRIC

Mood disturbance _____

ENDOCRINE

Heat/cold sensitive ____
Excessive thirst ____
Excessive hunger ____
Excessive urination ____
Burning in feet ____

FOR OFFICE USE ONLY:
Provider told pt. to discuss any abnormals with PCP
_____
_____
_____
_____

Patient Name: _____Chart #: _____ Date:_____

PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist before? ( ) Yes ( ) No If so, when?_____

Do you have skin test results? ( ) Yes ( ) No (If so, please bring skin test results to office)

Have you ever been on allergy shots? ( ) Yes ( ) No If so, are you still taking them? ( ) Yes ( ) No

If so, approximately how long did you take them? _____ When did you quit? _____

CURRENT MEDICATION:

Please list all current medications you are taking to relieve your allergy symptoms:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list all other medications you are taking regularly:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all medications you take occasionally (e.g., Tylenol, sleeping pill, etc):_____
_____
_____

DRUG ALLERGIES:

Please list all medications to which you are allergic:

1. Penicillin ( ) Yes ( ) No
2. Sulfa ( ) Yes ( ) No
3. Aspirin ( ) Yes ( ) No
4. Other (please list): _____
   _____

MEDICAL HISTORY:

Please list all significant medical problems such as Diabetes, High Blood Pressure, Heart Disease, Stomach Ulcer, Glaucoma, Seizure Disorder, Thyroid Disease, etc.:

_____
_____
_____
_____
_____

SURGICAL HISTORY & HOSPITALIZATIONS:

Please list all hospitalizations and surgeries in order of most recent first:

		YEAR:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

Patient Name: _____Chart #: _____ Date:_____

FAMILY HISTORY:

Please mark any that apply to blood relatives.

	Mother	Father	Siblings	Children	Other
Asthma	( )	( )	( )	( )	( )
Hayfever	( )	( )	( )	( )	( )
Sinus Problems	( )	( )	( )	( )	( )
Immune Deficiency	( )	( )	( )	( )	( )
Cystic Fibrosis	( )	( )	( )	( )	( )
Hives	( )	( )	( )	( )	( )
Eczema	( )	( )	( )	( )	( )
Food Allergy	( )	( )	( )	( )	( )
Auto-Immune Disease	( )	( )	( )	( )	( )

SOCIAL HISTORY:

How many people are living at home? _____

Smoking History:

Do you currently smoke? ( ) Yes ( ) No Have you ever smoked? ( ) Yes ( ) No
How many years have you smoked? _____
How many packs per day? _____
Have you ever quit as long as 6 months? (please explain) _____
If you have smoked in the past, what year did you stop smoking? _____
How many years did you smoke and how much? _____

Recreation

Please list your favorite hobbies: _____
_____

Employment

Where are you employed (or attend school)? _____
Job description? _____
Anything at work or school bother your allergies? _____
_____
_____
Number of days missed from work/school per year because of allergy, sinus or asthma problems? _____

If patient is a child, does he/she attend day care? _____
If yes, how many days per week? _____

Patient Name: _____Chart #: _____ Date:_____

The Allergy, Asthma & Sinus Center

Medication Restrictions for Allergy Skin Testing

Some medications can interfere with allergy skin testing. In order for us to obtain the most accurate results, please use the following guidelines for temporarily discontinuing these medications as you may be skin tested.

Medication	Generic Name	DO NOT TAKE FOR:
Alavert/Claritin/Claritin D/Clarinex	Loratadine	Seven (7) days
Allegra/Allegra D	Fexofenadine	Seven (7) days
Ataraz/Vistaril	Hydroxyzine	Seven (7) days
Zyrtec/Zyrtec D/Xyzal	Cetirizine/ Levocetirizine	Seven (7) days
Doxepin	Sinequan	Seven (7) days
Antivert	Meclizine	Five (5) days
Astelin/Patanase/Astepro Nasal Spray	Azelastine	Two (2) Days
Brovex	Brompheniramine	Two (2) Days
Pedlox	Chlorpheniramine	Two (2) Days
Periactin	Cyproheptadine	Two (2) Days
Phenergan	Promethazine	Two (2) Days
Tavist	Clemastine	Two (2) Days
Axid/Pepcid/Tagament/Zantac	Ranitidine	Two (2) Days
Allergy/Antihistamine Eye Drops: prescription or over-the counter e.g. Visine A, Naphcon A, Optivar, Elestat, Patanol		Two (2) Days
All other over-the-counter antihistimines, cough, cold & sleep medications e.g. Tylenol PM, Chlor trimeton, Benadryl		Two (2) Days

Please continue taking all of the following medications as prescribed: asthma, insulin, steroids, antibiotics, blood pressure medications, and antidepressants.
DO *NOT* STOP these medications without your doctor's approval.

Any questions regarding the medication restrictions or any other medication, please contact our office by calling **(865) 584-0962** or toll free **(800) 600-7551**.

Patient Name: _____Chart #: _____ Date:_____

AUTOMATED CONFIRMATION NOTICE:

To better serve you, The Allergy, Asthma & Sinus Center has implemented an automated appointment reminder system to provide you with the courtesy of a timely, efficient reminder of your next appointment. You have the option to receive either a phone call confirmation or a text message confirmation. If you so choose, you can opt out of receiving any appointment reminders. Please initial beside the appropriate selection below.

_____ I would like to receive a phone call for appointment reminders/confirmations. I want to receive my appointment reminder/confirmation calls at this phone number: _____

You will be able to either confirm or cancel your appointment using your telephone keypad. You will receive a call three (3) days prior to your appointment to inform you of vital information such as the name of the provider you are scheduled to see and the date, location and time of your appointment. If you do not confirm your appointment at this time, you will receive a second abbreviated appointment reminder call two (2) days before your appointment. If you are unavailable when you are called and you have a voicemail or answering machine, the system will leave you a brief message. If you are unable or fail to press the correct key when you receive a confirmation call, please contact our scheduling department at (865) 584-0962 or (800) 600-7551.

_____ I would like to receive a text message for appointment reminders/confirmations.

You will receive a text message to confirm your appointment three (3) days before your appointment. You will be able to confirm this appointment by responding with 'YES' and a unique pin number. If you need to cancel or reschedule your appointment, we ask that you call our scheduling department at (865) 584-0962 or (800) 600-7551.

_____ I do **not** want to receive **any** appointment reminders via call or text message.

My preferred time to receive appointment reminders is:

_____ Morning _____ Afternoon _____ Evening

Patient Name: _____Chart #: _____ Date:_____

Allergy Associates, PA, dba The Allergy, Asthma & Sinus Center

HIPAA DISCLOSURE

I understand that under the Health Insurance Portability & Accountability Act, (HIPAA), of 1996 I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in my medical record at The Allergy Asthma & Sinus Center, (AASC), or may be received from outside health entities and filed in my medical record. I understand that this information can and will be used by AASC to: (a) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly, (b) obtain payment from third-party payers, (c) conduct normal healthcare operations such as quality assessments and physician certifications, (d) notification of educational events specific to my medical condition through AASC or networking organizations, and (e) to researchers for IRB approved research, if I am a participant in a clinical trial. I understand that AASC or its business associate may contact me to provide appointment reminders, and information about treatment alternatives and other health-related benefits and services that may be of interest to me.

I understand that AASC may provide health information to assist in my care or for identification purposes in the event of a disaster unless I express my objection to such disclosures on this Acknowledgment.

☐ I agree ☐ I object

I have been informed of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand AASC has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 6701 Baum Drive, Suite 140, Knoxville, TN 37919. I understand that I may request, in writing, that AASC restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but, if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that I have taken action relying on this consent.

Signature: _____ Date: _____
Parent/Guardian

RELEASE OF INFORMATION AUTHORIZATION

☐ AASC **may not** discuss my healthcare and **may not** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may** discuss my healthcare and **may** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may not** discuss my healthcare, but **may** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may** discuss my healthcare, and **may** discuss and/or make financial arrangements **with only the individuals listed below**:

Name: _____Relationship:_____

Name: _____Relationship:_____

I prefer to be contacted in the following manner:

Phone Number:_____ Phone Number:_____

☐ Leave a message with contact number only. ☐ Do NOT leave a message.

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO THE FOLLOWING INDIVIDUALS OR COMPANIES:

Allergy Associates, PA, dba The Allergy, Asthma & Sinus Center Phone: (865) 584-2411 Fax: (865) 584-6384

Signature: _____ Date: _____
Parent/Guardian

ePrescribing Consent

ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribing program. These include:

- Formulary & Benefit Transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication History Transactions: Provides the physician with information about medications the patient is already taking to minimize the opportunity of potential adverse drug interaction
- Fill Status Notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription was picked up, was not picked up or was partially filled.

By signing this consent form, you are agreeing that Allergy Associates, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes and that Allergy Associates, PA may share information related to your medications and/or health with other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Allergy Associates PA to enroll me in the ePrescribe Program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction

Signature: _____ Date: _____
Parent/Guardian