ALLERGY & ASTHMA AFFILIATES
SRINAGESH PALUVOI, M.D.
Diplomate, American Board of Allergy and Immunology

PATIENT REGISTRATION (PLEASE PRINT CLEARLY)

NAME: First	Middle	Last	Date of birth	Social Security
HOME: Address	apt#	City	State	Zip Code
Occupation:	Martial Status	SEX	Home phone	Cell phone
Employer:	Address			Work phone
Parent or Spouse Name:	Parent or Spouse Employer		E-Mail	
Parent or Spouse Address			Spouse or Parent Work phone	
Emergency Contact:	Relationship:		Home Phone	Work Phone
Emergency Contact Address				
Referring Physician:	Address		Telephone	
Primary Care Physican	Address		Telephone	

BILLING AND INSURANCE INFORMATION

Primary Insurance Company Name:	ID or Policy Number	Group Number
Insurance Company Address:	Subscriber's Social Security #	Date Effective
Subscriber's Name / Sex	Home Phone	Relationship to Patient
Subscriber's Address	Work Phone	Subscriber's Date of Birth
MY INSURANCE DOES OR DOES NOT REQUIRE AN REFERRAL for allergy treatment i.e office visit, serum, allergy shots, other outpatient procedures. **PLEASE CIRCLE** Note:if neither is circled, we will assume NO referral is required.		
Individual Responsible for bill Full Name:		Relationship to Patient
Home Address:	City	State

WE ONLY FILE SECONDARY INSURANCE FOR MEDICARE PATIENTS

Secondary Insurance Company Name:	ID or Policy Number	Group/ Code
Insurance Company Address:	Subscriber's Social Security	Date of Effective
Subscriber's Name / Sex	Home Phone	Relationship to Patient
Subscriber's Address	Work Phone	Subscriber's Date of Birth

PATIENT'S AUTHORIZATION

I _____, hereby authorize Allergy and Asthma Affiliates Inc., to apply for benefits on my behalf for covered services rendered. I request payment by_____ (name of Ins. Co.) be made directly to Allergy and Asthma Affiliates Inc. (or in the care of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Adminstration and Health Care Financing Administration) and/ or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the release of any medical or other information necessary to process my insurance claim(s). I understand that as a patient or the responsible party for a patient, I am ulitmately responsible for payment of my bill. I also take full responsibility for obtaining a valid referral, and agree to be responsible for the cost of collection efforts including reasonable attorney's fees.
Our policy is that payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card, or money order.

_____ _____

Date Signature of Subsciber or Beneficiary

The above information is still valid: _____ Date: _____

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Please check off as many answers as apply to your (your child's) history. Not all of these questions will be related to your chief concerns or symptoms, nevertheless, they are questions which are part of your complete allergy, asthma or immunology history. As you fill out the form, do not worry about going into detail about abnormal areas as the doctor will review these answers in detail during your visit. Even if your major concern in very specific, (such as insect allergy) please complete all areas. Thank you in advance for helping to obtain a thorough and accurate history !

NAME:_____ AGE_____ OCCUPATION_____

CHIEF SYMPTOM:_____ DATE SYMPTOMS APPEARED___/___/___

Primary problems are worse:
- ☐Spring ☐Summer ☐Fall ☐Winter
- ☐All year
- ☐In the day ☐at night ☐No difference
- ☐Work days ☐Days off from work
- ☐School days ☐Weekends
- ☐Changes of weather or season
- ☐After a cold
- ☐After being outside ☐Wind
- ☐Upon exposure to irritants (smoke, cologne, perfume)
- ☐After eating any food
- ☐After eating_____
- ☐In moldy, musty areas
- ☐Upon lying down
- ☐Driving in a car ☐After flying
- ☐After drinking alcohol
- ☐When angry, sad or upset
- ☐After exercise
- ☐After sun exposure
- ☐After taking medicines such as:
- _____
- ☐_____

(Please do not write in this area)

Main symptoms are improved with:
- ☐Air conditioning
- ☐Travel or vacation away from home
- ☐Medication_____
- _____
- _____
- ☐Other_____
- _____

Infancy:
Normal ☐pregnancy ☐labor ☐delivery
Abnormal ☐pregnancy ☐labor ☐delivery
- _____
- _____
- ☐Breast fed for_____
- ☐Formula fed with_____
- ☐Colicky infancy

Skin Problems: I (my child) has had, or has:
- ☐Eczema It started at age_____
- ☐Hives ☐In the past ☐Now
- ☐Contact dermatitis ☐Poison Ivy
- ☐Psoriasis
- ☐Seborrheic dermatitis
- ☐Athletes foot or fungal infections ☐Now

Bath soap we use is_____
Shampoo I use is_____
Laundry detergent we use is_____
☐Dryer sheet type fabric softeners are used.

Eye Symptoms:
☐Itching ☐Redness ☐Discharge

Respiratory mucous membranes:
- ☐Headaches ☐Migraines ☐Sinus infections
- ☐Ear infections ☐Number of courses of antibiotics per year is_____
- ☐Drip ☐Clear Drip ☐Cloudy drip
- ☐Post Nasal drip ☐Throat clearing
- ☐Congestion ☐AM ☐PM ☐Both
- ☐Sneezing ☐Itchy nose
- ☐Rubbing of the nose (nasal Salute) ☐Nose bleeds
- ☐Itching of the roof of the mouth ☐Itching in the throat or ears
- ☐Popping or clicking of the ears
- ☐Mouth breathing ☐ Snoring ☐ Sleep apnea
- ☐Frequent cough ☐ Every day cough
- ☐Cough is dry ☐Cough brings up mucous
- ☐Shortness of breath ☐Wheezing ☐Chest tightness ☐Asthma
- ☐Hospitalized for asthma ☐Admitted to ICU for asthma
- ☐Exercise is limited by shortness of breath (chest congestion)
- ☐Exercise is limited by muscle fatigue (legs tire first)
- ☐Emergency room visits for breathing problems
- ☐Croup episodes ☐RSV BRONCHIOLITIS
- ☐Frequent or chronic bronchitis

Gastrointestinal:
- ☐Heartburn, belching, burping, acid reflux
- ☐Nausea
- ☐Vomiting
- ☐Abdominal pain
- ☐Constipation
- ☐Diarrhea
- ☐Malabsorption
- ☐Irritable bowel
- ☐Crohnn's disease
- ☐Ulcerative colitis

Insect Sting Reactions
- ☐I have only had local reactions at the site of the sting.
- ☐I (my child) has had difficulty breathing or swallowing hives, itching, or reactions at a spot other than where the sting occurred.
- ☐I (my child) have (has) an EPI-PEN or ANA-KIT
- ☐I (my child) have (has) received venom shots
- ☐I (my child) has a medic-alert bracelet

FAMILY MEDICAL HISTORY:

	MOTHER	FATHER	SIBLINGS	CHILDREN
ASTHMA	☐	☐	☐	☐
ALLERGY	☐	☐	☐	☐
FOOD ALLERGY	☐	☐	☐	☐
DRUG ALLERGY	☐	☐	☐	☐
INSECT ALLERGY	☐	☐	☐	☐
RECURRENT INFECTION	☐	☐	☐	☐

Other significant family history:

☐ Patient was adopted and family history is not available.

☐ Patient was adopted. I am aware of a family history of _____

_____

SOCIAL AND ENVIRONMENTAL HISTORY:

Please answer these points as they pertain to the **patient**.

Main residence is
- ☐ Single family home
- ☐ Townhouse
- ☐ Apartment
- ☐ Condominium
- ☐ Trailer
- ☐ College dormitory
- ☐ In a woody area
- ☐ In a sunny place
- ☐ In a low lying damp area
- ☐ New (1-5 years old)
- ☐ 5-10 years old
- ☐ 10-20 years old
- ☐ Over 20 years old

Patient has lived in home for _____ years.
- ☐ Home had previous owners.
- ☐ Previous owners had ☐ dog ☐ cat
- ☐ In an urban area
- ☐ In a suburban area
- ☐ In a rural area

I often visit with friends or family who:
- ☐ Smoke
- ☐ Have a cat _____
- ☐ Have a dog _____
- ☐ Symptoms are worse after visiting.

Patient's home has
- ☐ Central gas forced air (vents)
- ☐ Central electric forced air
- ☐ Central electric and gas
- ☐ Oil fired hot water heating
- ☐ Baseboard heat
- ☐ Radiator heat
- ☐ Mostly wall to wall carpet
- ☐ Mostly area rugs
- ☐ Dog _____
- ☐ Cat _____
- ☐ Birds _____
- ☐ Hamsters _____
- ☐ Gerbils _____
- ☐ Mice _____
- ☐ Cockroaches _____
- ☐ Plants (live potted)
- ☐ Salt water aquarium
- ☐ Smoker other than patient _____
- ☐ Regular pest control (exterminator)
- ☐ Central electrostatic air filter
- ☐ Central electronic air filter
- ☐ Filter is changed regularly
- ☐ Filter is washed regularly
- ☐ Barn with ☐ horses ☐ _____
- ☐ Leather sofa ☐ Non-leather furniture
- ☐ Fireplace ☐ Wood stove
- ☐ Musty moldy odor s

Patient's bedroom has
- ☐ Wall to wall carpet
- ☐ Ceiling fan
- ☐ Dog enters bedroom
- ☐ Dog sleeps on the bed
- ☐ Cat enters bedroom
- ☐ Cat sleeps on the bed
- ☐ Floor fan
- ☐ Area rug only
- ☐ HEPA filter
- ☐ Cool mist humidifier
- ☐ Other humidifier
- ☐ Stuffed toys ☐ on the bed
- ☐ Live potted plants
- ☐ Window A/C unit
- ☐ Regular mattress
- ☐ Water bed
- ☐ Futon
- ☐ Feather pillow
- ☐ Down comforter
- ☐ Allergen proof (vinyl/plastic) mattress encasings
- ☐ Allergen proof pillow encasings
- ☐ Bunk beds
- ☐ Patients sleeps on ☐ top bunk ☐ bottom bunk

Patient's lifestyle includes
- ☐ Cigarette smoker _____ pk/day
- ☐ Alcohol ☐ mild ☐ moderate ☐ heavy ☐ none
- ☐ Home day care _____ days/week
- ☐ Commercial day care ___ d/wk
- ☐ Animal at day care _____
- ☐ Preschool _____ days/week
- ☐ Animals in preschool _____
- ☐ Elementary school _____ grade
- ☐ Middle school _____ grade
- ☐ High school _____ grade
- ☐ College ☐ Fr ☐ So ☐ Jn ☐ Se
- ☐ Work ☐ Full time ☐ Part time

What kind of work do you do ____

_____
- ☐ Work environment has toxins, chemicals, hazards, dusts (organic or inorganic)
- ☐ Work environment is clean
- ☐ There are smokers at work
- ☐ There are animals at work ____
- ☐ There are cockroaches at work or at school.
- ☐ Windows do not open at work
- ☐ Regular exercise _____
- ☐ Very sedentary lifestyle
- ☐ High risk practices for AIDS
- ☐ Hobby is _____

REVIEW OF SYSTEMS

These questions refer to problems/symptoms the patient might have, but which he or she did not think were related to the chief complaint for which the appointment was made. Just check those areas of concern.

- ☐ Fatigue
- ☐ Weight loss
- ☐ Fevers
- ☐ Night sweats
- ☐ Skin changes
- ☐ Hair loss or changes
- ☐ Skin color changes
- ☐ Dry eyes
- ☐ Glaucoma
- ☐ Dry mouth
- ☐ Teeth
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Sense of smell
- ☐ Hearing
- ☐ Swallowing
- ☐ Hoarseness
- ☐ Voice changes
- ☐ Cough ☐ with blood
- ☐ Tuberculin test (PPD)
- ☐ Chest pain
- ☐ Shortness of breathe upon lying down
- ☐ Palpitations
- ☐ Blood pressure
- ☐ Heartburn
- ☐ Nausea or vomiting
- ☐ Antacid use
- ☐ Abdominal pain
- ☐ Kidney problems
- ☐ Urine problems
- ☐ Prostate problems
- ☐ Joint pain
- ☐ Swelling ankles
- ☐ Constipation
- ☐ Diarrhea
- ☐ Transfusion in the past
- ☐ Diabetes
- ☐ Intolerance for heat or cold
- ☐

DIAGNOSTIC STUDIES

Please check if the patient has had any of these studies. If you remember when & where they were done, please note it.

- ☐ Chest X-ray _____
- ☐ Sinus X-ray _____
- ☐ Sinus CAT scan _____
- ☐ CAT scan chest _____
- ☐ CAT scan abdomen _____
- ☐ Nuclear medicine study _____
- ☐ Sweat test _____
- ☐ Biopsy skin or other _____
- ☐

PREGNANCY- LMP-ETC

- ☐ Pregnant now _____ weeks
- ☐ Possibly pregnant now
- ☐ Periods began age _____
- ☐ Menopause at age _____
- ☐ Asthma worsens with the period
- ☐ Symptoms worsen with the period

☐ Letter dictated to _____

FOOD ALLERGY:

☐Patient does not have any food allergy or intolerance.
☐Patient has had allergic or adverse reactions to:
☐Milk
☐Eggs
☐Wheat
☐Orange
☐Corn
☐PEANUT
☐NUTS
☐Tomato
☐Soybean
☐Fish
☐Shellfish
☐Banana or avocado or kiwi or peach
☐Other
☐Sulfite preservatives ☐MSG (Chinese restaurant syndrome)
☐Patient has had life threatening reactions to:

☐Patient has an EPI-PEN or ANA-KIT

PAST ALLERGY EVALUATIONS AND TREATMENTS:

☐Patient had allergy skin tests ☐Year was_____
☐Patient had RAST (blood) tests for allergy
☐Patient had allergy shots for _____ ☐months ☐years
☐Shots helped ☐Shots did not help
☐Patient had a systemic or serious reaction to an allergy shot or skin test
☐Patient would like to receive shots ☐again ☐for the first time

SEVERE RECURRENT OR CHRONIC INFECTIONS:

☐Patient has had pneumonia. ☐X-Ray did show pneumonia
☐Recurrent ear infections from age_____
☐Ear tubes have been placed. If yes, how many times_____

☐Chronic or frequent sinus infections occur. ☐CAT scan of sinuses was done
☐Meningitis
☐Hepatitis or ☐Mono
☐Chronic diarrhea or ☐intestinal parasites
☐Low antibody or gammaglobulin levels have been found
☐Abscesses of the skin or internal organs
☐Infection of the bones or joints
☐Patient is in a high risk group for AIDS
☐Patient has received gammaglobulin

PAST MEDICAL AND SURGICAL HISTORY:

☐Patient has no other active medical problem.
☐Patient has had or has other medical problems including:
☐Glaucoma
☐High blood pressure
☐Abnormal heart rhythms
☐Migraines
☐Depression
☐Diabetes
☐Seizures
☐Thyroid
☐Other

☐Patient has not had any surgeries.
☐Adenoids were removed at age_____ ☐Tonsils removed at age_____
☐Appendix removed at age_____ ☐Gall bladder out at age_____
☐Ear tubes at age_____ _____ _____ _____
☐Sinus surgery
☐Hernia repair ☐Vasectomy
☐Hysterectomy ☐Partial only ☐Total (uterus and ovaries)
☐Other surgery or hospitalization was for:

Patient's family physician, pediatrician, or internist is: Dr._____

Patient's other doctors or surgeons are: Drs._____

MEDICATIONS: Please check box if patient is taking these medicines now, or if they have been taken in the past. Add to the list if necessary.

☐Eye drops for glaucoma
☐Other eye drops
☐Blood pressure medicine
☐Heart medicine
☐Migraine prevention medicine
☐BETA-BLOCKERS
☐Oral contraceptives
☐Aspirin
☐Arthritis medicines
☐Tylenol
☐Vitamins
☐Steroid pills, prednisone, medrol, or others
☐ALBUTEROL (Ventolin, Proventil)

☐Asthma Inhalers

☐Antihistamines

☐Decongestants

☐Cortisone or steroid injections

☐Others: 1.
2.
3.
4.
5.
6.

DRUG ALLERGIES: Please check box if patient has had any allergic or adverse reactions to these medicines. Add to the list if necessary.

☐Penicillin (i.e. amoxicillin, ampicillin)
☐Cephalosporins (i.e. Ceclor, Ceftin, Cefzil, Vantin, Keflex)
☐Sulfa type antibiotics (i.e. Bactrim, Septra, TMP/SMZ)
☐Tetracycline (i.e. Doxycycline, Minocin)
☐Erythromycin (i.e. E-Mycin, Biaxin, Zithromax)
☐Quinolone antibiotics (i.e. Cipro, Levaquin, Trovan)
☐Theophylline (i.e. Slo-Bid, Theo-Dur, Uniphyl)
☐Aspirin ☐Tylenol
☐Non-steroidal anti-inflammatory drugs (i.e. Motrin, Advil, Nuprin, Aleve, Ibuprofen, etc.)
☐Decongestants
☐Steroids (i.e. cortisone)
☐Topical creams, ointments, or solutions.
☐Preservatives (i.e. sulfites, thimerisol, benzalconium chloride)
☐Others: 1.

2.

3.

4.

5.

☐Patient is allergic to latex or rubber products.