Allergy & Asthma Associates of Allen

977 Raintree Circle, Suite 100, Allen, Tx. 75013
Tel 972.747.7007
Fax 972.747.7006

Medical History

Name: ____Date: _____________________

Gender: (   ) Male (   ) Female   DOB: _______________________________________Age:___________________________

Did a physician refer you to our office? (   ) Yes (   ) No If yes, Doctor's Name: ____

Primary Care Physician's Name: ____

Reason for visit: ____

Duration of Condition: ____

Describe the most distressing symptoms you feel are caused by your allergy:

____
____
____
____

List all medications you have tried in the past for allergy (all oral, topical and nasal sprays) and the response you had to each:

____
____
____
____

Have you ever had allergy skin testing? (   ) Yes (   ) No

Date of testing: ________________________________Physician's name: ____

Have you ever been on allergy shots? (   ) Yes (   ) No   Date(s): ____

Have you had sinusitis? (   ) Yes (   ) No   Frequency: ____

Have you ever had a sinus X-ray or CT? (   ) Yes (   ) No   Dates: ____

Have you ever been diagnosed with Asthma? (   ) Yes (   ) No

List family members with allergy problems: ____

Have you tested positive for (   ) HIV (   ) Hepatitis B (   ) Hepatitis C

Social History:

How long have you lived in Dallas? ____

How long have you lived in your current home? ______________________________Years ____________________________Months

Is there an obvious mold problem? (   ) Yes (   ) No   Area of home: ____

Type of flooring (include bedroom): ____

History of smoking: (   ) Yes (   ) No   How long? ____________________   Packs per day: _____________________

Prolonged cigarette smoke exposure: (   ) Yes (   ) No

Occupation: ____

Hobbies: ____

Pets: (   ) Dog (   ) Cat (   ) Other: ____
(   ) Indoor (   ) Outdoor (   ) Both
Review of Systems: (please circle all symptoms you may have)

Headaches
Sinus pain
Eyes: Redness
Tearing
Itch
Puffiness
Nose: Colds
Discharge
Stuffiness
Hay fever
Itch
Bleeding
Sneezing
Snoring
Sinusitis
Ears: Frequent infection
Pain
Hearing loss
Chest Asthma
Chronic cough
Shortness of breath
Bronchitis/pneumonia

Skin: Eczema
Contact dermatitis
Angioedema/hives
Dry
Itchiness
Atopic dermatitis
GI: Nausea/vomiting
Appetite changes
Reflux symptoms
Lactose intolerance
Changes in bowel habits
GU: Infection
Incontinence
General: Weight loss/gain
Emotional problems
Sleep pattern
Missed school/work
Females: Abnormal menstrual periods
Menopause

Past Medical History:

History of Surgery (include sinus surgery):

Known allergies to medications (List names and symptoms you had):

____

____

All current medications (include allergy medications):

____

____

____

____

(Women only)
Are you currently or might be pregnant? (   ) Yes (   ) No
Are you planning or attempting to become pregnant in the near future? ____________________

Allergy & Asthma Associates of Allen

Patient: ____
Last First MI

Address: ____
Street City State Zip

Home Telephone: ____________________________________Cell Phone: _______________________________

Social Security#: _________________________________Drivers License #: ______________________________

Date of Birth: ____Age: _______________Gender: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Other

Employer: ____Work#: __________________________

Work Address: ____Email: ___________________________

In case of emergency notify: ____

Relationship: ___________________Telephone#: ____________________Alternate#: ______________________

Primary Insurance Company: ____

Name of Insured: ____Relationship to Patient: ________________

Identification #: _______________________________________Group #: _______________________________

Insured's Date of Birth: ___________________Insured's Employer: ____________________________________

Insurance Telephone Number (Benefits line or Member's Services): ____

Who is your PRIMARY CARE PHYSICIAN? ____

Who referred you to our office? ____

FINANCIAL AGREEMENT AND AUTHORIZATION OF TREATMENT

I understand that I am required to give my current insurance card, driver's license, and billing information for insurance to be filed on my behalf. I also understand that I will notify Allergy & Asthma Associates of Allen of any changes in my insurance or billing information. If accurate billing and insurance information is not given then I will be responsible for all charges incurred due to timely filing requirements by my insurance company. I am also responsible for services denied by my insurance company as "non-covered" or "not medically necessary." I authorize the treatment of the person named above and agree to pay for all fees for such treatment. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pending of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process insurance claims and also request payment of Government benefits either to me or the party that accepts assignment below.

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Signature on File: ____Date: ____________________

Relationship to patient: ____