Allergy & Asthma Specialty Center

# NEW PATIENT INTAKE FORM

**NAME**: _____ **DOB**: _____ **SEX**: MALE FEMALE

**ADDRESS**: _____ **ZIP CODE**: _____

**PHONE #**: _____ - _____ - _____ **WORK#**: _____ - _____ - _____

**PHARMACY: _____ PHARMACY #:** _____ - _____ - _____

**WOULD YOU BE INTERESTED IN HAVING ACCESS TO YOUR MEDICAL RECORDS ONLINE?** YES / NO

**E-MAIL ADDRESS**: _____ **@**_____

**REFERRED BY**: _____ **IS THIS YOUR PRIMARY CARE DOCTOR?** YES / NO

**IF NOT, WHAT IS THE NAME OF YOUR PRIMARY CARE DOCTOR?** _____

**EMERGENCY CONTACT NAME**: _____ **PHONE #**: _____ - _____ - _____

**IS THIS YOUR**: PARENT CHILD SPOUSE FRIEND OTHER: _____

**ARE YOU A CURRENT SMOKER**? YES / NO

**ARE YOU A FORMER SMOKER**? YES / NO WHEN DID YOU QUIT? _____

**HAVE YOU HAD A PNEUMONIA VACCINE**? YES / NO

**HAVE YOU RECEIVED YOUR FLU VACCINE THIS SEASON**? YES / NO

**DO YOU HAVE ANY ALLERGIES TO MEDICATIONS**? YES / NO

**IF YES, PLEASE LIST**: _____

_____.

**DO YOU TAKE ANY MEDICATIONS, VITAMINS, HERBS OR SUPPLEMENTS**? YES / NO

| NAME OF MEDICATION | STRENGTH | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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1. **HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?**

   Never  Monthly or less  2-4 times/month  2-3 times/week  4 or more times/week

2. **HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST YEAR?**

   1-2 Drinks  3-4 Drinks  5-6 Drinks  7-9 Drinks  10+ Drinks

3. **HOW OFTEN DID YOU HAVE 6 OR MORE DRINKS ON ONE OCCASION IN ONE YEAR?**

   Never  Less than monthly  Monthly  Weekly  Daily

## MEDICAL HISTORY

PAST OR CURRENT CONDITIONS FOR THE PATIENT:

☐ALLERGIES/HAY FEVER ☐HIGH BLOOD PRESSURE ☐ASTHMA ☐ECZEMA ☐LUNG DISEASE

☐INFECTIOUS DISEASE ☐ IMMUNE DISEASE ☐DIABETES ☐LIVER DISEASE ☐KIDNEY DISEASE

☐NEUROLOGICAL DISEASE ☐HIGH CHOLESTEROL ☐CANCER ☐CARDIOVASCULAR DISEASE

☐OTHER: _____

## FAMILY HISTORY

PAST OR CURRENT CONDITIONS FOR FAMILY MEMBERS:

| | | | | | | |
|---|---|---|---|---|---|---|
| **MOTHER** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **FATHER** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **CHILDREN** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **MATERNAL GRANDMOTHER** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **PATERNAL GRANDMOTHER** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **MATERNAL GRANDFATHER** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **PATERNAL GRANDFATHER** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |
| **SIBLINGS** | ☐ Allergies | ☐ Asthma | ☐ Immune Disease | ☐ Eczema | ☐ Hives | ☐ Swelling |

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# REVIEW OF SYMPTOMS

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

IN THE LAST 2-4 WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

**EARS**
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Ear Itching

**NOSE**
- ☐ Runny Nose
- ☐ Itching Nose
- ☐ Sneezing
- ☐ Nose Bleeds
- ☐ Post Nasal Drips
- ☐ Nasal Congestion

**THROAT**
- ☐ Sore Throat
- ☐ Throat Itching
- ☐ Throat Swelling
- ☐ Tongue Swelling

**NEUROLOGICAL**
- ☐ Headache
- ☐ Weakness in Limbs
- ☐ Numbness

**GENERAL**
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

**EYES**
- ☐ Eye Itching
- ☐ Eye Redness
- ☐ Eye Swelling
- ☐ Eye Drainage
- ☐ Vision Changes

**RESPIRATORY**
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest Tightness
- ☐ Sputum
- ☐ Cough

**HEME/LYMPH**
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Enlarged Lymph Nodes

**CARDIOVASCULAR**
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Difficulty Laying Flat

**MUSCULOSKELETAL**
- ☐ Joint Swelling
- ☐ Joint Pain
- ☐ Joint Stiffness

**GASTROINTESTINAL**
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Heartburn

**SKIN**
- ☐ Itching
- ☐ Rash
- ☐ Hives
- ☐ Swelling
- ☐ Eczema

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ONLY IF YOU ARE EXPERIENCING SYMPTOMS OF THE EYES & NOSE

Mini-Juniper: Circle the number that best describes how troubled you have been in the past 2-4 weeks with your symptoms.

| 0 = Not at all | 1 = Hardly | 2 = Somewhat | 3 = Moderate | 4 = Quite A Bit | 5 = Very | 6 = Extremely |
|---|---|---|---|---|---|---|

**ACTIVITIES**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Regular Activities at Home, Work or School | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Recreational Activities or Hobbies | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Sleep | **0** | **1** | **2** | **3** | **4** | **5** | **6** |

**PRACTICAL PROBLEMS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Need to Rub Eyes or Nose | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Need to Blow Nose Repeatedly | **0** | **1** | **2** | **3** | **4** | **5** | **6** |

**NOSE SYMPTOMS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Sneezing | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Stuffy/Blocked Nose | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Runny Nose | **0** | **1** | **2** | **3** | **4** | **5** | **6** |

**EYE SYMPTOMS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Itchy Eyes | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Sore Eyes | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Watery Eyes | **0** | **1** | **2** | **3** | **4** | **5** | **6** |

**OTHER SYMPTOMS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Tiredness/Fatigue | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Thirst | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| Feeling Irritable | **0** | **1** | **2** | **3** | **4** | **5** | **6** |

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ONLY IF YOU HAVE ASTHMA, COMPLETE THIS FORM!

# ASTHMA CONTROL TEST

Please circle which number applies to you for the following questions.

In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at home, work and school?
1=all of the time
2=most of the time
3=some of the time
4=little of the time
5=none

During the past 4 weeks, how often have you had shortness of breath?
1=more than once a day
2=once a day
3=three to six times a week
4=once or twice a week
5=none

During the past 4 weeks, how often did your symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?
1=four or more nights a week
2=two or three nights a week
3=once a week
4=once or twice a month
5=none

During the past 4 weeks, how often have you used your rescue inhaler or nebulizer machine?
1=three or more times a day
2=one or two times a day
3=two to three times a week
4=once a week or less
5=none

How would you rate your asthma control during the past 4 weeks?
1=not controlled at all
2=poorly controlled
3=somewhat controlled
4=well controlled
5=completely controlled

Total Score: _____ / 25

# Chronic Urticaria (Hives)

## Quality of Life Questionnaire (CU-$Q_2$oL)

Patient name: Date:

| 1=Not at all | 2=A little | 3=Somewhat | 4=A lot | 5=Very much | Circle Score |
|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Pruritus (itching) | 1 | 2 | 3 | 4 | 5 |
| 2. Wheals (welts, raised hives) | 1 | 2 | 3 | 4 | 5 |
| 3. Eyes swelling | 1 | 2 | 3 | 4 | 5 |
| 4. Lip swelling | 1 | 2 | 3 | 4 | 5 |
| 5. Urticaria interferes with my work | 1 | 2 | 3 | 4 | 5 |
| 6. Urticaria interferes with my physical activities | 1 | 2 | 3 | 4 | 5 |
| 7. Urticaria interferes with my sleep | 1 | 2 | 3 | 4 | 5 |
| 8. Urticaria interferes with my spare time | 1 | 2 | 3 | 4 | 5 |
| 9. Urticaria interferes with my social relationships | 1 | 2 | 3 | 4 | 5 |
| 10. Urticaria interferes with my eating behaviour | 1 | 2 | 3 | 4 | 5 |
| 11. Do you have difficulties in falling asleep? | 1 | 2 | 3 | 4 | 5 |
| 12. Do you wake up during the night? | 1 | 2 | 3 | 4 | 5 |
| 13. Do you feel tired during the day because of your bad night sleep? | 1 | 2 | 3 | 4 | 5 |
| 14. Do you have difficulties in keeping concentration? | 1 | 2 | 3 | 4 | 5 |
| 15. Do you feel nervous? | 1 | 2 | 3 | 4 | 5 |
| 16. Do you feel in a bad mood? | 1 | 2 | 3 | 4 | 5 |
| 17. Do you have to put some limit in choosing your food? | 1 | 2 | 3 | 4 | 5 |
| 18. Does urticaria limit your sport activities? | 1 | 2 | 3 | 4 | 5 |
| 19. Are you troubled by drugs' side effects? | 1 | 2 | 3 | 4 | 5 |
| 20. Are you embarrassed due to urticaria symptoms? | 1 | 2 | 3 | 4 | 5 |
| 21. Are you embarrassed in going to public places? | 1 | 2 | 3 | 4 | 5 |
| 22. Do you have any problems in using cosmetics? | 1 | 2 | 3 | 4 | 5 |
| 23. Do you have any limits in choosing clothes material? | 1 | 2 | 3 | 4 | 5 |

Total CU-$Q_2$oL score _____

# Allergy and Asthma Specialty Center

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides is with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating, that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at Allergy and Asthma Specialty Center. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request Dr. Rana Bonds to perform a reasonable and necessary medical examination, testing and treatment for the condition in which has brought me to seek care at this practice. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Print Patient Name

Signature of Patient/Personal Representative Date

Relationship to Patient

Signature of Witness Date