

Happy New Year!

I wish you best wishes for the New Year. However, with the New Year comes a new deductible for 2020.

Medicare Patients

If you have met your deductible of \$198 then this does not apply to you: Medicare deductible for 2020 is \$198.00. We ask that you please pay \$65.00 for your office visit at the time of service which will be applied to your deductible of \$198.00. If you have seen another doctor since January 1st, you have incurred some medical expenses. Most Medicare supplements do not cover the first \$198.00. We appreciate your confidence in us, and we apologize for having to bring up the money issue.

Commercial Patients

If you have met your deductible, then this does not apply to you: Commercial insurance deductibles vary from hundreds to thousands of dollars. If you are a New Patient, we ask that you pay \$300.00 towards your office visit at the time of service to help meet your deductible. If you are an established patient, we ask that you please pay \$75.00 towards your office visit at the time of service. We appreciate your confidence in us, and we apologize for having to bring up the money issue.

Respectfully,

Ashok R. Patel M.D.

Before you sign, please read the following information carefully.

I will ask questions and promptly voice my concerns. I will give full and accurate information as it relates to my health, including prescription and non-prescription medications. I will report any changes in my symptoms, including pain, and request assistance from a healthcare team. I will educate myself, learn about the medical tests that will be performed and understand my treatment plan. I will follow my recommended treatment plan. I will be considerate of the staff and other patients. I will follow the facilities rules and regulations. I will respect the property that belongs to the facility or others. I will understand and honor financial obligations related to my care, including understanding my own insurance coverage.

I will keep my follow-up appointments as advised. Why?

Depending on my progress, during my follow- up visits:

1. Dr. Patel can change my medications: decrease the dose, stop them, or add new medications if needed. If I develop any side effects to the medications, he can evaluate and treat them appropriately.
2. Dr. Patel may recommend some tests to confirm or revise the diagnosis.
3. Dr. Patel can refer me to another specialist.
4. Dr. Patel may come up with some other ideas depending on the advances in medical knowledge.
5. Dr. Patel will discuss the results of my tests; he recommends discussing the results in person, not on the phone.

I understand that I am responsible for any adverse outcomes which may arise because I failed to keep my appointments. If I cannot keep my follow-up appointment, I will reschedule it and I will keep the rescheduled appointment. If I cannot afford my follow-up appointment, I will discuss it with Dr. Patel as he will try his best to help me on a sliding scale.

By not keeping the follow-up appointments, I have assumed responsibility for my further medical care including diagnosis, treatment, etc.

Patient signature

Date

Please answer the questions if they apply. Otherwise write NA, not applicable.

- **Have you been diagnosed with asthma?** Yes No If yes, when? _____
 - Do you use or have you used in the past an albuterol HFA or a nebulizer? YES NO
 - If yes, how often? 1-2 times a day 3+ times a day 2-3 times a week less than once a week

• **Tell us about your cough in the last 4 weeks by marking an (X) in the appropriate box**

	None	Mild	Moderate	Severe
▪ How bad is your Cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough at bedtime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough when you first wake up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough when you talk for prolong amount of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough when you laugh?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough when you sing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough when you cry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough when you drink or eat something cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Cough upon cold air exposure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• **Chest colds:**

- When you catch a cold, do you develop a severe cough: Yes No
- How many days the cough will last? _____
- How many episodes of chest colds in a year? _____
- What time of the year? _____ Spring _____ Summer _____ Fall _____ Winter

• **Other respiratory symptoms in last 4 weeks:**

	None	Mild	Moderate	Severe
▪ Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Chest congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Do you expectorate phlegm from the chest? <input type="checkbox"/> Yes <input type="checkbox"/> No				
▪ If yes, guess the amount of the phlegm from the chest you expectorate in 24 hours: _____ teaspoon(s)				

• **Nasal/sinus symptoms?**

	None	Mild	Moderate	Severe
▪ Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Does your nose run like a faucet, with water-like discharge?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Does your nose run when you bend over?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Does your nose run only on one side?			<input type="checkbox"/> Right	<input type="checkbox"/> Left
▪ Does your pillow get stained because of runny nose at night?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Does your nose run mostly in winter, upon exposure to cold air?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Any injury to the head?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? _____
▪ Have you undergone any nasal or sinus surgery?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? _____
▪ How is your sense of smell?		<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> None
▪ Have you been diagnosed with Nasal Polyps?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? _____
▪ Number of nasal polyp surgeries? _____				

• **Are your respiratory symptoms worse at certain times of the year?**

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
▪ Nasal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Eye symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Chest symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▪ **PREVIOUS ALLERGY EVALUATION AND TREATMENT:**

- Have you ever had an allergy skin test? Yes No If yes, when? _____
- Have you ever received allergy injections? Yes No If yes, when? _____
- Have you undergone any Chest X-Ray's? Yes No If yes, when? _____ Where? _____
- CT of the Chest? Yes No If yes, when? _____ Where? _____
- Have you coughed up blood in the sputum? Yes No

• **SLEEP: Please talk to your primary care provider for further evaluation and treatment.**

Excessive Daytime Sleepiness Yes No Snoring Yes No Stop Breathing in Sleep Yes No

Do you use supplemental oxygen? Yes No

▪ **PERSONAL/SOCIAL HISTORY:**

- Marital status: Single Married/Partner Divorced Separated Widowed
 - Children: Yes No
 - Pets: Dogs Cats Birds Other: _____
 - Race/Ethnicity: _____ Preferred Language: _____
-

▪ **ENVIRONMENTAL/OCCUPATIONAL HISTORY:**

- Occupations, current and past: _____
 - Are you exposed to anything at work that might aggravate your condition? Yes No
If yes, please give more information? _____
 - Are your symptoms better on off days, weekends, holidays, vacation? Yes No
 - What do you do to cool your home? Central Air Swamp Cooler Open Windows Fans
 - Are you aware of any exposure to the following: Candles Air Fresheners Any other strong odors
 - Other exposures of concern: _____
-

▪ **ADVERSE REACTIONS TO MEDICATIONS:**

	Name of the medications	Symptoms?	When?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

• **SMOKING HISTORY (if it applies):**

- Do you currently smoke? Yes No
 - Cigarettes ___ pack/day Cigar Pipe E-cig Marijuana Vape CBD
 - Did you smoke in the past?
 - Cigarettes ___ pack/day Cigar Pipe E-cig Marijuana Vape CBD
 - Age started: _____ Age Stopped: _____ Average packs/day: _____
 - Total no. of years you smoked: _____
 - Smoker(s) at home: Yes No Who: _____
 - If you are smoking, please quit: <https://smokefree.gov/quit-smoking/getting-started/steps-to-manage-quit-day> or call 1-800-QUIT-NOW
-

• **ALCOHOL OR SUBSTANCE USE:**

- Do you drink alcohol? Yes No If yes, _____ day _____ week _____ month _____ year
 - What do you drink? _____
 - Have you had any problems with alcohol? Yes No
 - Do you use any illegal drugs? Yes No
-

• **FAMILY HISTORY:**

	Name of Disease:	Your Relationship:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

• **HOSPITALIZATIONS & SURGERIES:**

- Sinus Surgery Yes No If yes, When? _____
 - Lung Surgery Yes No If yes, When? _____
 - Tonsillectomy Yes No If yes, When? _____
 - Adenoidectomy Yes No If yes, When? _____
 - Others? _____
-

• **FALL RISK ASSESSMENT:**

- Have you fallen in the past year? Yes No
- Do you have difficulty getting around, or with balance? Yes No
- Are you afraid of falling? Yes No

Please contact other providers for further evaluation and treatment.

• **DEPRESSION SCREENING:**

- Do you have a diagnosis of Depression? Yes No If yes, When? _____
- Are you currently taking a medication for depression? Yes No

Over the past 2 weeks, have you been bothered by any of the following problems?

- Little interest or pleasure in doing things? Yes No
 - Feeling down, depressed, or hopeless? Yes No
-

• **IMMUNE SYSTEM:**

▪ **Adult (Ages 18+)**

- Two or more new ear infections within 1 year Yes No
- Two or more new sinus infections within 1 year, in the absence of allergy Yes No
- One pneumonia per year (x-ray proven) for more than 1 year Yes No
- Chronic diarrhea with weight loss Yes No
- Recurrent viral infections (colds, herpes, warts, condyloma) Yes No
- Recurrent need for intravenous antibiotics to clear infections Yes No
- Recurrent, deep abscesses of the skin, lymph nodes or internal organs Yes No
- Persistent thrush or fungal infections on skin or elsewhere Yes No
- Infections with normally harmless tuberculosis-like bacteria Yes No
- A family history of primary immunodeficiency Yes No

▪ **Child (Ages 0-17)**

- Four or more ear infections within 1 year Yes No
- Two or more severe sinus infections within one year Yes No
- Two or more months of antibiotic treatment with little effect Yes No
- Two or more pneumonias per year Yes No
- Insufficient weight gain or growth delay Yes No
- Recurrent deep skin or organ abscesses Yes No
- Persistent thrush in mouth or fungal infection on skin Yes No
- Need for intravenous antibiotics to clear infections Yes No
- Two or more deep seated infections Yes No
- A family history of a primary immunodeficiency Yes No

REVIEW OF SYSTEMS (Please talk to your primary care provider for evaluation of the following symptoms/issues)

• **Ear, nose, mouth and throat:**

- Earache Yes No
- Mouth Sores Yes No
- Ear Infections Yes No _____ per year
- Throat Tightness Yes No
- Hearing Loss Yes No
- Hoarseness Yes No
- Nosebleeds Yes No
- Enlarged Lymph nodes Yes No

• **BLOOD AND LYMPH NODES:**

Easy Bleeding Yes No
History of blood infection Yes No

• **HEART:**

Shortness of breath Yes No
Ischemic heart disease Yes No
Irregular Heartbeat Yes No
Swelling of Ankles/Legs Yes No

• **STOMACH:**

Do you have a burning feeling behind your breastbone (heartburn)? Yes No
Do the contents of your stomach move upwards to your throat or mouth (regurgitation)? Yes No
Do you have difficulty getting a good night's sleep because of your heartburn and/or regurgitation? Yes No
Do you take additional medication for your heartburn and/or regurgitation, other than what the physician told you to take?
(such as Tums, Roloids, Maalox?) Yes No
Spleen removed? Yes No

• **GENITOURINARY:**

Urinary Tract Infections Yes No _____ per year

• **MUSCLES AND BONES:**

Joint Stiffness Yes No
Joint Swelling Yes No
Joint Pain Yes No

• **NEUROLOGIC (BRAIN):**

History of Meningitis Yes No
Headaches Yes No

• **PSYCHOLOGIC (MOOD):**

Mood Swings Yes No
Panic Attacks Yes No

I understand that Dr. Patel will not evaluate and treat all the symptoms I have marked above in this form. After he talks to me and examines me, he will decide which symptoms and medical problems he will evaluate and treat.

Signature of the Patient/Guardian

Date

Patient Name: _____ Date: _____

HIVES Questionnaire

Please answer the following questions only if you have hives or welts; the questions do not apply if you have eczema or rash. If you are not sure, please ask us.

- For how long you have been suffering from hives? _____
- Do your hives come and go? Yes No
- How long one hive, one spot, lasts before it subsides? _____ hours, _____ days, _____ weeks?
- Does one hive last more than 24 hours in the same spot? Yes No
- When the hives go away, does the skin become completely normal? Yes No
- Is there a bruise mark after the hive subsides? Yes No
- Are the hives? Itchy Painful Burning _____
- Where do the hives occur? Face Arms Trunk Palms Legs Buttocks Soles Other: _____
- When your hives erupt, do you also develop? Aching Joint pain Chills Fever Nausea Abdominal pain
 Tightness of the throat or chest Palpations Other: _____
- Do antihistamines control your hives? Yes No
- Do you develop swelling of the lip, tongue, eyelid, or other parts of the body? Yes No
- How long does the swelling last? _____ hours, _____ days, or _____ weeks?
- Do you develop difficulty in breathing because of the swelling of the tongue or throat? Yes No
- What do you believe is causing your hives? _____

- Does any of the following trigger or make your hives worse?
 - When your body gets warm/hot Yes No
 - Sweating Yes No
 - Exercise Yes No
 - Exposure to cold weather, snow, or ice Yes No
 - Shower or bath Yes No
 - Pressure points such as waistline Yes No
 - Scratching of your skin Yes No
 - Vibration because of vibrating tools Yes No
 - Exposure to the sun Yes No
 - Are your hives worse during menstrual cycle? Yes No

- Do you think any food causes hives? Yes No Name of the foods: _____

 - Do you think food additives causes hives? Yes No Name of the foods: _____

-

Sometimes ibuprofen and naproxen (Aleve) can cause or make hives worse.

How often do you take ibuprofen or naproxen (Aleve)? _____ times in a Day Week Month

How many milligrams? Ibuprofen _____ Naproxen _____

Many patients do not realize the association of ingestion of ibuprofen or naproxen and breaking out of hives. Please try to remember the time you took ibuprofen or naproxen and the time hives developed.

- Did you take ibuprofen or naproxen several hours before the outbreak of the hives? Yes No
- How many hours before the outbreak of hives did you take ibuprofen or naproxen? _____

Signature of the Patient/Guardian

Date

FOOD/DRUG ALLERGY QUESTIONNAIRE

Are you on any special diets? Yes No

Are you avoiding any foods/drugs? Yes No

If yes, please list in the table below:

Name of Food/Drug			
Amount of Food/Drug Ingested			
Symptoms			
How quickly the symptoms start?	Immediately Within minutes _____ minutes Within hours ____ hours Within days _____ days	Immediately Within minutes _____ minutes Within hours ____ hours Within days _____ days	Immediately Within minutes _____ minutes Within hours ____ hours Within days _____ days
Duration of Symptoms			
What did you do for the treatment?			
When did the reaction happen?			
Have you eaten the food again?			
If so, was there a reaction again?			

Signature of the Patient/Guardian

Date

STOP

