All Allergy, Asthma & Immunology Clinic, P.A.
Sonak B. Doshi M.D.
10216 Garland Road | Dallas, Texas - 75218
270 S. Collins Rd, #300 | Sunnyvale, Texas - 75182
3600 Gaston Ave Wadley Tower #1056 | Dallas, Texas - 75246

Patient Name: _____
Birthday: _____
Name of person completing form: _____
Date: _____

Date : _____

Patient Last Name : _____

Patient First Name : _____ MI : _____

Address : _____

City : _____ State : _____ Zip : _____

Home phone : _____ Cell phone : _____

Sex : _____ Birthdate : _____ Age : _____

Social Security # : _____ Drivers License # : _____ State : _____

Marital status : _____ Email : _____

Employer : _____ Work Phone : _____ Ext : _____

Name of Party Responsible for Payment, if other than Patient : _____

DOB : _____ SS # : _____ DL # : _____

Employer : _____ Ph # : _____

Address of Responsible Party : _____

City : _____ State : _____

Zip : _____ Phone : _____ Relationship of Responsible Party to Patient : _____

Nearest Relative Not Living with you : _____ Phone : _____

Address Of Relative : _____

City : _____ State : _____ Zip : _____

Please list other members of your family who are patients here and their relationships to you :

_____

Who May We Thank for Referring You to Our Office? : (Please specify by name) Doctor : _____

Friend : _____ Hospital : _____ Phone book : _____

Family : _____

What is your medical Coverage? : ☐ HMO ☐ EPO/POS ☐ PPO ☐ Indemnity ☐ Medicare

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Date: _____

Who is your PRIMARY CARE PHYSICIAN? : _____ PH# : _____

PRIMARY Insurance : _____ Group # : _____ Policy #: _____

Claims address : _____

City : _____ State : _____ Zip : _____ Ph# : _____

Insured : _____ Relation to Patient : _____ Sex : _____

SS# : _____ DOB of Insured : _____ Employer : _____

Emp. Address : _____

City : _____ State : _____ Zip : _____

SECONDARY Insurance : _____ Group # : _____ Policy #: _____

Claims address : _____

City : _____ State : _____ Zip : _____ Ph# : _____

Insured : _____ Relation to Patient : _____ Sex : _____

SS# : _____ DOB of Insured : _____ Employer : _____

Emp. Address : _____

City : _____ State : _____ Zip : _____

****

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT :

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency 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 an insurance claim and also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature X _____ Date : _____

IF PATIENT UNDER AGE 18: Dr. Sonak Daulat and his staff have my permission to exam and treat _____

Signature of Parent or Guardian : X _____ Witness : _____

Thank you for choosing our office for your health care needs. We look forward to serving you.

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Date: _____

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

THE MAIN REASON FOR THIS VISIT TODAY IS (ARE) : (CHECK ALL THAT APPLY)

NASAL SYMPTOMS :

- ☐ Sneezing
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Itchy watery eyes
- ☐ Itchy nose
- ☐ Itchy roof of mouth
- ☐ Loss of sense of smell
- ☐ Frequent clearing of throat
- ☐ Itchy ears
- ☐ Frequent nasal bleeding
- ☐ Post nasal drip
- ☐ Bad breath
- ☐ Sore throat
- ☐ History of polyps or nasal septal deviation
- ☐ "Addiction" to nasal sprays
- ☐ Transfer of allergy care from Dr. _____
- ☐ Continuation of allergy injections
  Started _____ years ago.

ASTHMA SYMPTOMS :

- ☐ Frequent cough
- ☐ Shortness of breath
- ☐ Wheezing or cough
- ☐ At night - How often? _____
- ☐ With exercise
- ☐ Chest Pain
- ☐ Rapid heart rate
- ☐ How many hospitalizations for asthma? _____
- ☐ Date of last hospitalization _____
- ☐ How many ER Visits for asthma? _____

FREQUENT INFECTIONS :

- ☐ Sinus infections
  Number per year _____
  Date of last antibiotic _____
- ☐ Ear infections
  Number per year _____
  Date of last antibiotic _____
- ☐ Pneumonia
  Number in lifetime _____
  Date of last episode _____
  Date of Pneumovax injection _____
- ☐ Other infections
  Please describe _____

FREQUENT HEADACHES :

- ☐ History of migraine headaches
- ☐ History of tension headaches
- ☐ Triggered by known factors such as stress, caffeine, certain foods
- ☐ Associated nausea, vomiting or visual problems
- ☐ Have had a CAT scan - Date : _____

Describe location _____
Describe frequency _____

OTHER SYMPTOMS :

- ☐ Insect sting reaction
- ☐ Skin rash - contact dermatitis
- ☐ Skin rash - eczema
- ☐ Abdominal pain or diarrhea

LIST OTHER CONCERNS OR SYMPTOMS HERE:

_____

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THESE SYMPTOMS OCCUR : (Check all that apply)

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ Year - round
- ☐ Days or weeks at a time
- ☐ Worse at home
- ☐ Worse at work or school
- ☐ Worse in A.M.
- ☐ Worse in P.M.
- ☐ Worse outdoors
- ☐ All day

SYMPTOMS ARE MADE WORSE BY : (Check all that apply)

- ☐ Cold
- ☐ Cigarette smoke
- ☐ Mowing grass
- ☐ Raking Leaves
- ☐ Dusting
- ☐ Perfumes
- ☐ Strong odors
- ☐ Alcoholic beverages
- ☐ Heat
- ☐ Exercise
- ☐ Animal danders
- ☐ cats ☐ dogs
- ☐ Other

LIST ALL CURRENT MEDICATIONS : (including vitamins, laxatives, Tylenol and aspirin)

_____ _____ times per day
_____ _____ times per day
_____ _____ times per day
_____ _____ times per day
_____ _____ times per day
_____ _____ times per day
_____ _____ times per day

LIST ALL PREVIOUS ALLERGY OR ASTHMA MEDICATIONS : (including antihistamines such as Claritin, Zyrtec; nasal sprays such as Afrin, nasal steroid sprays such as Vancenase, Nasacort, or Flonase; and asthma medications including inhalers, theophylline, and nebulizer medications)

_____ ☐ Helped ☐ No Help ☐ Drowsy ☐ Jittery
_____ ☐ Helped ☐ No Help ☐ Drowsy ☐ Jittery
_____ ☐ Helped ☐ No Help ☐ Drowsy ☐ Jittery
_____ ☐ Helped ☐ No Help ☐ Drowsy ☐ Jittery
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CURRENT ENVIRONMENT : (Check if present)

- ☐ Cats
- ☐ Dogs
- ☐ Birds
- ☐ Other Pets
- ☐ Feather pillows
- ☐ Down comforter
- ☐ Carpets or rugs
- ☐ Air cleaner
- ☐ Cigarette Smoke
- ☐ Forced air heating
- ☐ Air conditioning: central
- ☐ Air conditioning: window units
- ☐ Lots of house plants
- ☐ Mold growth
- ☐ Improvement on trips
- ☐ Exposure to latex or rubber

Currently living in :
- ☐ a house
- ☐ an apartment
- ☐ a mobile home

Constructed of :
- ☐ brick
- ☐ frame
- ☐ mixed
- ☐ stucco/stone

Located in :
- ☐ the city
- ☐ the suburbs
- ☐ the country

Current residence is _____ years old. The carpet is _____ years old. The mattress is _____ years old.

Please list any areas of special concern : (i.e. history of water damage, specific pets, etc.)

PAST ALLERGY HISTORY :

Have you been allergy tested in the past? ☐

If Yes, answer the following questions :

Tested by Dr. _____ in year _____ Location of Doctor : _____

Allergic to : ☐ Trees ☐ Grass ☐ Weeds ☐ Dust Mites ☐ Molds ☐ Danders
other _____

Previous allergy shots? ☐ Still on shots? ☐

Were (are) allergy shots helpful for you? ☐

Have you ever had a severe reaction to allergy shots? ☐

Please describe history of the reaction :

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PAST MEDICAL HISTORY :

Please list the name and address of your primary care physician and the names of any other physicians whom you have seen in the past 2 years :

_____

_____

Would you like a report of your allergy evaluation sent to your primary care Doctor? ☐ Yes ☐ No

Hospitalizations : (age or year)

_____ for _____

_____ for _____

_____ for _____

_____ for _____

SURGERIES : (include tonsillectomy, adenoidectomy, ear and nasal surgeries)

_____ for _____

_____ for _____

_____ for _____

_____ for _____

Emergency Visits :

_____ times in the past year for _____

_____ times in the past five years for _____

Drug allergies : (list the name of the drug and the symptoms it caused and approximate date)

_____Caused _____ in (year) _____

_____Caused _____ in (year) _____

_____Caused _____ in (year) _____

_____Caused _____ in (year) _____

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Adverse reactions to immunizations : (include reactions to flu, pneumonia, tetanus, diptheria and measles shots)

_____ Caused _____ in (year) _____

_____ Caused _____ in (year) _____

Other chronic health conditions : (include diabetes, hypertension, heart disease, elevated cholesterol, irritable bowel syndrome, hiatal hernia, thyroid disease, and nerve or psychiatric problems)

FAMILY HISTORY :

	Allergies	Asthma	Frequent Coughing	Frequent Infections	Other please list
Father	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	_____
Brother(s)	☐	☐	☐	☐	_____
Sister(s)	☐	☐	☐	☐	_____
Grandfather(s)	☐	☐	☐	☐	_____
Grandmother(s)	☐	☐	☐	☐	_____
Uncle(s)	☐	☐	☐	☐	_____
Aunt(s)	☐	☐	☐	☐	_____
Cousin(s)	☐	☐	☐	☐	_____

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Date: _____

SOCIAL HISTORY:

Children

(complete this side if patient is less than 18 years old)

Birth weight : _____

Premature : _____

Describe any complications of delivery : _____

Development Delays : _____

Please Describe : _____

Breast Fed : _____

Diet and feeding concerns :

_____

Parents Are :

☐ Divorced ☐ Separated

☐ Both Deceased ☐ Married

Primary Residence is :

☐ One Home ☐ Split

Siblings (List names and ages) :

_____

Name of school or daycare : _____

Grade : _____

School performance :

Smoke Exposure : _____

Place of birth : _____

Cities or states of residence since birth :

_____

Adult

(complete this side if patient is more then 18 years old)

Place of birth : _____

Cities or states of residence since birth : _____

Current Occupation : _____

Marital Status :

☐ Single ☐ Married

☐ Divorced ☐ Separated

Please Describe :

Children : _____ How many ? _____

Hobbies : _____

Do you smoke or have you smoked in the past :

[ ] Yes [ ] No Times per day : _____

How many years : _____

Quit when? : _____

Do you need help Quitting? : _____

Alcohol Consumption :

☐ Never ☐ Rarely

☐ On special occasions ☐ Moderate

☐ Heavy

Drug Use History :

☐ Marijuana ☐ Cocaine

☐ Other

Do you engage in routine exercise?

☐ Yes ☐ No ☐ Sometimes

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REVIEW OF SYSTEMS : (Check all that apply)

- ☐ Fever
- ☐ Weight changes _____ lbs.
- ☐ Night Sweats
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Visual Changes
- ☐ Deafness
- ☐ Ringing in Ears
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Failure
- ☐ Valvular Heart Disease (including Mitral Valve Prolapse)
- ☐ TB or Pleurisy
- ☐ Emesis
- ☐ Jaundice
- ☐ Heart Burn
- ☐ Kidney
- ☐ Nausea
- ☐ Inflammatory bowel disease
- ☐ Diarrhea
- ☐ Major Depression
- ☐ Recurrent Urinary Tract Infections
- ☐ Arthritis
- ☐ Muscular Disorders
- ☐ Bruising
- ☐ Seizures
- ☐ Hair Changes
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Mood Disorder
- ☐ Breast Cancer
- ☐ Strokes
- ☐ Dry Skin
- ☐ Itching
- ☐ Skin Rashes
- ☐ Diabetes

Please comment on boxes checked above:

Thank you for completing this allergy/health history as accurately and as thoroughly as possible.

Signature of person completing this form : _____ Date: _____