Dr. Mark H. Schecker
Allergist

Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

Dear New Patient:

We look forward to meeting you on _____ at _____ in our office.

Coastal Carolina Allergy & Asthma Associates, P.C. appreciates your selection of this office to serve your Allergy and Asthma needs, and will do everything possible to provide you with the very best of care. In order to do so, we ask that you please review the enclosed information sheets carefully. We have attempted to give you as much information about our practice as possible and to anticipate your questions and needs regarding our policies and procedures.

The need for allergy skin testing will be determined at your initial visit, and may be done that day if appropriate. If not it will be scheduled at another time. If skin testing is done, results will be available immediately. Some medications may need to be stopped before skin testing appointments. Never stop any medication without first consulting this office or the prescribing physician.

3516 Caduceus Drive · Myrtle Beach, SC 29588
Phone: (843) 293-0093 · Fax: (843) 293-0096
www.MyrtleBeachAllergist.com

COASTAL CAROLINA ALLERGY AND ASTHMA ASSOCIATES, P.C.
3516 CADUCEUS DRIVE
MYRTLE BEACH, SC 29588
PHONE # (843) 293-0093
DR. MARK SCHECKER

Dear Patients,

We are writing to provide you with important information regarding our billing policies. Please take a minute or two to read this letter.

Our practice relies on the timely payment of the fees charged for services we provided you in order to continue to provide you with quality care. Although we currently bill several health insurance companies, as well as Medicare and Medicaid, the responsibility of the account balance lies with the patient. In the case of a child who is the patient, the payment responsibility lies with the child's parents or guardians.

The fee for an initial office visit ranges from $90.00 to $430 depending on the type and complexity of the medical condition. There are additional fees for allergy testing and other diagnostic services. The cost of testing and diagnostics services is determined by the nature of the problem. These fees range from $80.00 to $910.00.

When no health insurance is available to pay these charges, the patient is required to remit payment in full. If a patient has health insurance they are expected to pay their insurance company's contracted amount at the time of the office visit. If you believe you have met your health insurance deductible we require you to provide our office with written verification that the deductible has been met.

It is every patient's responsibility to check with their health insurance company prior to their visit to obtain a full explanation of their covered benefits for allergy care. If there are questions about the billing of health insurance, please call our business office to discuss this with them.

The importance of **bringing your insurance card with you to each office visit** cannot be over-emphasized. If you are enrolled in a health insurance program that requires a primary care physician referral, you are responsible for obtaining the referral and bring it with you.

Patients may continue to pay by cash, check with proper identification, MasterCard, VISA, American Express and Discover. If a bank returns a check to our office for insufficient funds we will attempt to collect the funds from the bank two times. If your account still does not have sufficient funds after those attempts, the amount due will be charged back to your account. An administrative service charge of $30 will be applied for each check returned due to insufficient funds.

Lastly, if you are unable to make a scheduled appointment, please notify our office **24 hours in advance**. If you are running 15 or more minutes late for your scheduled appointment please call our office for possible rescheduling. If you do not, we may <u>not</u> be able to work you in the schedule that day.

Thank you for entrusting us with your medical care. If you have any questions, or would like to discuss our billing policies, please don't hesitate to give us a call.

COASTAL CAROLINA
ALLERGY & ASTHMA

ABOUT ALLERGY

Dear Patient:

If the doctor determines that you may be allergic he will order testing to find out what specific sensitivities you may have. Therefore, if testing is ordered for you, you should know the following. Each testing session is done in one or two stages depending on what has been ordered. The initial testing, called the prick method, is done on the back. After waiting a period of 15–20 minutes the area is checked for reactions that may have occurred. Any item that does not react during the initial testing is retested on the arm by the intradermal method. The intradermal method requires the injection of a very small amount of the allergen into the superficial layers of the skin. Reactions are evidenced by areas of swelling (wheals), redness, and itching. People who are highly allergic may have local reactions that take several days to disappear, however, the large majority are resolved within 30 minutes.

There are certain medications that interfere with allergy testing. Therefore, you will be given an abbreviated list of medications you can and cannot take before testing. On rare occasions a patient may experience a more severe reaction to testing, which may consist of the following: itching (especially of the ears and scalp), asthma, hives, weakness, dizziness, and nausea. When such reactions occur they are readily treated by our doctor.

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Patient Instruction/Consent Form for Allergy Skin Testing

Skin Test: Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

Prick Method: The skin is pricked with a needle where a drop of allergen has already been placed.

Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

You will be tested to important airborne allergens and possibly some foods. These include, trees, grasses, weeds, molds, dust mites, and animal danders and, possibly some foods. Prick (also known as percutaneous) tests are usually performed on your arms or back. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. You may be scheduled for skin testing to antibiotics, caines, venoms, or other biological agents. The same guidelines apply.

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PRECAUTIONS

1. No prescription or over the counter oral antihistamines should be used 4 to 5 days prior to scheduled skin testing. These include cold, cough and sinus medications, hay fever medications, or oral treatments for itchy skin, over the counter allergy medications, such as Claritin, Zyrtec, Allegra, Actifed, Dimetapp, Benadryl, hydroxyzine (Atarax), and many others. Prescription antihistamines such as Clarinex and Xyzol should also be stopped at least 5 days prior to testing. If you have any questions whether or not you are using an antihistamine, please ask the nurse or the doctor. In some instances a longer period of time off these medications may be necessary.

2. You should discontinue your nasal and eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, or Astelin up to 5 days before the testing. In some instances a longer period of time off these medications may be necessary. If you have any questions whether or not you are using an antihistamine, please ask the nurse or the doctor. In some instances a longer period of time off these medications may be necessary.

3. Medications such as over the counter sleeping medications (e.g. Tylenol PM) and other prescribed drugs, such as amytriptyline hydrochloride (Elavil), doxepin (Sinequan), and imipramine (Tofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving skin test after consultation with your physician. Please make the doctor or nurse aware of the fact that you are taking these medications so that you may be advised as to how long prior to testing you should stop taking them. If you are taking antidepressants, psychotropic or anitreflux medications, they may have antihistaminic properties and should be discussed with the doctor prior to testing.

YOU MAY

1. You may continue to use your intranasal allergy sprays such as Flonase Rhinocort, Nasonex, Nasacort, Omnaris, Veramyst and Nasarel.

2. Asthma inhalers (inhaled steroids and bronchodilators) and oral theophylline (Theo-Dur, T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed. Leukotriene antagonist s (e.g. Singulair, Accolate) should be held the night before testing.

3. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking (bring a list if necessary).

Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional mild or very rare severe reactions may require immediate therapy. Talk to your doctor about any further details. Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed

until after the pregnancy in the unlikely event of a reactions to the allergy testing and beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

Please note that reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment.

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens are prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours notice, due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized.

COASTAL CAROLINA
ALLERGY & ASTHMA

Skin Testing

Allergy and Asthma patients for whom allergy skin testing is found to be necessary must not use antihistamine compounds prior to the skin test appointment. These compounds include not only the "classic" antihistamines but also certain compounds with "antihistamine-like activity" such as the tricyclic antidepressants. These will be mentioned in the ensuing paragraphs.

NO PRESCRIPTION OR OVER THE COUNTER ANTIHISTAMINES SHOULD BE USED FOR 5 DAYS PRIOR TO THE SCHEDULED SKIN TESTING. THESE INCLUDE COLD TABLETS, SINUS TABLETS, HAY FEVER MEDICATIONS, OR ORAL TREATMENTS FOR ITCHY SKIN. THEREFORE, IT IS IMPORTANT TO READ THE PACKET LABEL. SOME OF THE NAMES OF THESE DRUGS INCLUDE ACTIFED, DRIXORAL, DIMETAPP, DRISTAN, ORNADE, BENADRYL, RONDEC, TRINALIN, CLARITIN(LORATADINE), ZYRTEC(CETIRIZINE), ASTELIN(AZELASTIN), ALLEGRA(FEXOFENADINE), AND MANY OTHERS.

As noted, certain other medications will also interfere with skin testing because they have "antihistamine-like" properties. These would include the tricyclic antidepressants (elavil/adapin/sinequan/surmontil/tofranil/amitrptyline/etc.). If you are taking one of these types of medications or certain tranquilizers, please notify us so that we can determine whether skin testing can be done.
THESE MEDICATIONS SHOULD NOT BE STOPPED UNLESS YOU HAVE DISCUSSED IT WITH US.

If your condition requires continuous administration of any of the above medications or if you have a question about a certain medication, please notify us so that we may discuss this with you and determine whether skin testing needs to be postponed.

You may continue to use plain decongestants (Sudafed, Entex) nasal steroid sprays (Nasonex, Rhinocort, Beconase, Nasocort, Vancenase, Nasalide), nasal cromolyn (Nasalcrom), and any antibiotics.
THESE WILL NOT INTERFERE WITH YOUR SKIN TESTING.

Asthma inhalers (Intal,beclomethasone (Beclovent, Vanceril), Aerobid, Flovent, Pulmicort, Advair, Serevent, Alupent, Brethaire, albuterol (Proventil, Ventolin) and oral theophylline (Theo-Dur, T-Phyl, Uniphyl) and oral albuterol do not interfere with skin testing and should be used as prescribed.

(OVER)

Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking.
Please let the physician and nurse know:

1. *If you are taking any beta blockers or antidepressants.*
2. *If you are pregnant.*
3. *If you have a fever or wheezing.*
4. *Any medications you are taking (bring a list if necessary).*

After skin testing, you will meet with your physician who will make further recommendations regarding your treatment.

PLEASE DO NOT CANCEL YOUR APPOINTMENT SINCE THE TIME SET ASIDE FOR YOUR SKIN TEST IS EXCLUSIVELY YOURS FOR WHICH SPECIAL ANTIGENS ARE PREPARED. IF FOR ANY REASON YOU NEED TO CHANGE YOUR SKIN TEST APPOINTMENT, PLEASE GIVE US AT LEAST 48 HOURS NOTICE. DUE TO THE LENGTH OF TIME SCHEDULED FOR SKIN TESTING, A LAST MINUTE CHANGE RESULTS IN LOSS OF VALUABLE TIME THAT ANOTHER PATIENT MIGHT HAVE UTILIZED.

COASTAL CAROLINA ALLERGY & ASTHMA
MARK SCHECKER MD (843) 293-0093

Specializing in the treatment of Allergy, Asthma, Sinus Disease, and Clinical Immunology in children and adults.

ANTIHISTAMINES INTERFERE WITH SKIN TESTING AND SHOULD BE STOPPED 5 DAYS IN ADVANCE. THE FOLLOWING IS A PARTIAL LIST OF SOME COMMON ANTIHISTAMINES:

Atarax/hydroxyzine
Actifed
Allegra/Allegra D
Allerest
Allerx
Antivert
Astelin
Astepro
Benadryl
Chlortrimeton
Clarinex/Clarinex D
Claritin/loratadine
Claritin D
Dimetapp
Dristan
Drixoral
Meclizine
Lodrane
Palgic
Pataday
Patanase
Periactin
Phenergan
Respa Hist
Rondec
Ru – Tuss
Rynatan
Sinarest
Tavist/Clemastine
Triaminic
Tussionex
Tylenol Allergy Sinus
Tylenol PM
Xyzal/levocetirizine
Zyrtec/Zyrtec D/Cetirizine C

Some Allergy EYEDROPS also contain ANTIHISTAMINES and should be STOPPED. Some of these available by prescription are *Pataday, Patanol, Optivar, and Bepreve.* Over the counter eye drops for Allergy may also contain Antihistamine.
IF YOU ARE NOT SURE ABOUT ANY MEDICATIONS PLEASE CALL OUR OFFICE FOR ASSISTANCE.

You can continue to take Decongestants such as *SUDAFED, Prescription Steroid, Nasel Sprays (E.G. Nasonex, Flonase) Asthma Medications, Prednisone, and antibiotics.*

THIS LIST MAY NOT BE COMPLETE. IF YOU HAVE ANY QUESTIONS ABOUT THE MEDICATIONS YO ARE TAKING, PLEASE CONTACT OUR OFFICE FOR ASSISTANCE.

COASTAL CAROLINA ALLERGY AND ASTHMA ASSC.,PC

DR. SCHECKER

PATIENT NAME_____**DATE**_____

Medication Chart

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Prescriptions					
Name of medicine	**Dose (total milligrams)**	**How many times per day?**		**Who prescribed it for you? (Physician's last name)**	**Why do you take it?**

Over-the-counter medications, herbal remedies, vitamins					

Update this every time you visit.

Authorization for Release of Information – Compound Release

Name of Patient: _____ Date of Birth: _____

COASTAL CAROLINA ALLERGY is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
Self ☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
Family or Friend ☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
Email communication-Provide email address* Not Applicable *For email communication to occur, please accept the disclosure below:	
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder _____
Self ☐ For **text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive text communication as selected.	
☐ Photo of patient received by patient or legal guardian	☐ Appointment reminder preference ☐ Text Communication OR ☐ Phone/Voicemail Communication

Self

Patient's Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

*** Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

Rev. 2020

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

COASTAL CAROLINA ALLERGY
_____ **may release the following information:**
(Name of the entity)

☐ Entire record ☐ Financial records ☐ Office visit notes

☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):

☐ Other as listed: _____

Entity or person who will receive the information:

Family or Friend

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Send the information electronically. Email address: Not Applicable

For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

*** Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

COASTAL CAROLINA ALLERGY & ASTHMA ASSOCIATES, P.C.

Allergy Questionnaire Instructions

Please fill out the questionnaire completely and accurately. It is an important part of your evaluation, aiding the collection and organization of information about your problems.

The questionnaire is best filled out at home where labels can be checked to determine such items as stuffing materials in pillows and cushions, and the name and dosage of medicines you are taking.

If there are any questions concerning this questionnaire, or other concerns, please call (843) 294-9494. Please bring these forms and your medicines with you for your appointment with Dr. Schecker.

If you find you are unable to make your scheduled appointment, please call our office twenty-four (24) hours before the scheduled time. We set aside time to be available to you and expect you to extend to us the same courtesy.

ALLERGY QUESTIONNAIRE

PLEASE PRINT CLEARLY

NAME (LAST) (FIRST)			DATE
BIRTHDATE	SEX ☐ MALE ☐ FEMALE	MEDICAL RECORD NUMBER	
ADDRESS (STREET)	(CITY)	(ZIP CODE)	
HOME PHONE ( )	WORK PHONE / DAY PHONE ( )	OCCUPATION	
WHO IS YOUR REGULAR PHYSICIAN?		HOBBIES	
MARITAL STATUS ☐ NOT MARRIED ☐ MARRIED	IF MARRIED, SPOUSE'S OCCUPATION	SPOUSE'S HOBBIES	
HOW MANY YEARS HAVE YOU LIVED IN S. CAROLINA ☐	INDICATE OTHER CITIES OF RESIDENCE AND YEARS LIVED THERE		

IF PATIENT IS A CHILD, COMPLETE THE FOLLOWING

FATHER'S COMPLETE NAME	AGE	OCCUPATION	HOBBIES
MOTHER'S COMPLETE NAME	AGE	OCCUPATION	HOBBIES

INDICATE THE MAJOR REASON(S) FOR ALLERGY REFERRAL

☐ 1. HAYFEVER ☐ 4. EAR PROBLEMS ☐ 7. HIVES ☐ 10. RECURRENT INFECTION

☐ 2. SINUS ☐ 5. BRONCHITIS ☐ 8. ECZEMA ☐ 11. REACTION TO INSECTS

☐ 3. ASTHMA ☐ 6. EYE PROBLEMS ☐ 9. DRUG ALLERGY ☐ 12. OTHER _____

IN YOUR OWN WORDS, DESCRIBE THE MOST DISTRESSING SYMPTOMS YOU FEEL ARE CAUSED BY YOUR ALLERGY?

ABOUT HOW OLD WERE YOU WHEN YOUR ALLERGY PROBLEM(S) BEGAN?

HOW DOES YOUR ALLERGY PROBLEM AFFECT YOUR LIFE?

SYSTEMS REVIEW *(CHECK ONLY BOXES FOR WHICH A PROBLEM EXISTS)*

	HOW MUCH			HOW OFTEN?		
EARS	*MILD*	*MODERATE*	*SEVERE*	*RARELY*	*OCCASIONALLY*	*DAILY*
ITCHING	☐	☐	☐	☐	☐	☐
EAR INFECTIONS	☐	☐	☐	☐	☐	☐
DRAINING	☐	☐	☐	☐	☐	☐
BLOCKED	☐	☐	☐	☐	☐	☐
POPPING	☐	☐	☐	☐	☐	☐
HEARING PROBLEMS	☐	☐	☐	☐	☐	☐
EYES	*MILD*	*MODERATE*	*SEVERE*	*RARELY*	*OCCASIONALLY*	*DAILY*
TEARING	☐	☐	☐	☐	☐	☐
ITCHING	☐	☐	☐	☐	☐	☐
SWELLING	☐	☐	☐	☐	☐	☐
PAIN	☐	☐	☐	☐	☐	☐
BLURRED VISION	☐	☐	☐	☐	☐	☐
NOSE/SINUSES	*MILD*	*MODERATE*	*SEVERE*	*RARELY*	*OCCASIONALLY*	*DAILY*
ITCHING	☐	☐	☐	☐	☐	☐
SNEEZING	☐	☐	☐	☐	☐	☐
CLEAR MUCUS	☐	☐	☐	☐	☐	☐
COLORED MUCUS	☐	☐	☐	☐	☐	☐
PLUGGED OR BLOCKED	☐	☐	☐	☐	☐	☐
POST NASAL DRIP	☐	☐	☐	☐	☐	☐
NOSE BLEEDS	☐	☐	☐	☐	☐	☐
SNORING	☐	☐	☐	☐	☐	☐
MOUTH BREATHING	☐	☐	☐	☐	☐	☐
LOSS OF SMELL	☐	☐	☐	☐	☐	☐

HAVE YOU EVER HAD SINUS X-RAYS?
☐ NO ☐ YES; *INDICATE APPROXIMATE DATE* ____

WHAT WERE RESULTS?

	HOW MUCH			HOW OFTEN?		
THROAT/MOUTH	*MILD*	*MODERATE*	*SEVERE*	*RARELY*	*OCCASIONALLY*	*DAILY*
BAD BREATH	☐	☐	☐	☐	☐	☐
ITCHING	☐	☐	☐	☐	☐	☐
PAIN	☐	☐	☐	☐	☐	☐
FREQUENT TONSILLITIS	☐	☐	☐	☐	☐	☐
HOARSENESS	☐	☐	☐	☐	☐	☐
COLD SORES	☐	☐	☐	☐	☐	☐
SWALLOWING PROBLEMS	☐	☐	☐	☐	☐	☐
SWOLLEN GLANDS	☐	☐	☐	☐	☐	☐

AGE OF ONSET OF PROBLEMS WITH: EARS ____ EYES ____ NOSE ____ THROAT ____

OTHER PROBLEMS WITH EYES, EARS, NOSE OR THROAT

	HOW MUCH			HOW OFTEN?		
CHEST PROBLEMS	*MILD*	*MODERATE*	*SEVERE*	*RARELY*	*OCCASIONALLY*	*DAILY*
ASTHMA	☐	☐	☐	☐	☐	☐
WHEEZING	☐	☐	☐	☐	☐	☐
COUGHING	☐	☐	☐	☐	☐	☐
TIGHTNESS	☐	☐	☐	☐	☐	☐
SHORTNESS OF BREATH	☐	☐	☐	☐	☐	☐
CONGESTION	☐	☐	☐	☐	☐	☐

AGE AT BEGINNING OF PROBLEM(S) ____

NUMBER OF EMERGENCY VISITS FOR ASTHMA: PAST YEAR ____ LIFETIME ____

HOW OFTEN ARE YOU AWAKENED BY ASTHMA?
☐ NEVER ☐ MONTHLY ☐ WEEKLY ☐ NIGHTLY

NUMBER OF TIMES HOSPITALIZED FOR ASTHMA: PAST YEAR ____ LIFETIME ____

NUMBER OF DAYS MISSED FROM WORK OR SCHOOL DUE TO ASTHMA IN THE PAST YEAR ____

DO YOU CHOKE OR VOMIT FREQUENTLY?
☐ NO ☐ YES

DID YOU HAVE SEVERE OR FREQUENT BRONCHIAL INFECTIONS *CHILD?* ☐ NO ☐ YES *ADULT?* ☐ NO ☐ YES

HAVE YOU HAD PNEUMONIA?
☐ NO ☐ YES ____ NUMBER OF TIMES

INDICATE IF YOU HAVE LIMITED PHYSICAL ACTIVITY DUE TO ASTHMA
☐ NONE ☐ OCCASIONAL ☐ RARELY ☐ DAILY

DO YOU OR HAVE YOU EVER SMOKED?
☐ NONE ☐ PAST ☐ PRESENT; *HOW MANY PACKS A DAY?* ____

HOW MANY YEARS HAVE YOU SMOKED? ____

DO YOU WANT TO STOP SMOKING? ☐ YES ☐ NO

IF YOU HAVE QUIT SMOKING, HOW MANY YEARS HAS IT BEEN? ____

CHECK APPROPRIATE BOX(ES) FOR THINGS THAT MAKE YOU FEEL WORSE

WHICH MONTHS OF THE YEAR ARE THE PATIENTS SYMPTOMS WORSE:	HAYFEVER OR NASAL SYMPTOMS	CHEST ASTHMA BRONCHITIS	OTHER SYMPTOMS (PLEASE SPECIFY)
SAME ALL YEAR	☐	☐	
SPRING (MAR-APR-MAY)	☐	☐	
SUMMER (JUN-JUL-AUG)	☐	☐	
AUTUMN (SEP-OCT-NOV)	☐	☐	
WINTER (DEC-JAN-FEB)	☐	☐	
HOUSE DUST	☐	☐	
MOWED GRASS	☐	☐	
RAKING LEAVES	☐	☐	
WINDY DAYS	☐	☐	
YARDS OR PARKS	☐	☐	
WEATHER CHANGES	☐	☐	
DAMONESS	☐	☐	
HEAT	☐	☐	
COLD	☐	☐	
AIR CONDITIONING OR DRAFTS	☐	☐	
NEWSPAPERS	☐	☐	
IRRITANT FUMES OR AEROSOLS	☐	☐	
SMOKE	☐	☐	
SMOG	☐	☐	
COSMETICS OR PERFUMES	☐	☐	
RAIN	☐	☐	
EXERCISE	☐	☐	
EMOTIONAL UPSET (CRYING)	☐	☐	
LAUGHING	☐	☐	
NIGHT TIME OR SLEEP	☐	☐	
ON AWAKENING	☐	☐	
AT WORK	☐	☐	
AT PLAY	☐	☐	
AT SCHOOL	☐	☐	
ON VACATION	☐	☐	
CATS	☐	☐	
DOGS	☐	☐	
BIRDS OR FETHERS	☐	☐	
DRIED FRUITS	☐	☐	
RESTAURANT MEALS	☐	☐	
BEER OR WINE	☐	☐	
MENSTRUAL PERIOD	☐	☐	
EGGS	☐	☐	
MILK OR DAIRY PRODUCTS	☐	☐	
NUT	☐	☐	
PEANUT	☐	☐	
SHELLFISH(SHRIMP/LOBSTERS/CLAMS)	☐	☐	
FISH	☐	☐	
OTHER	☐	☐	
OTHER	☐	☐	
MOUNTAIN TRIPS	☐	☐	
DESERT TRIPS	☐	☐	
BEACH TRIPS	☐	☐	
AWAY FROM HOME	☐	☐	
AWAY FROM WORK	☐	☐	
AIR CONDITIONING	☐	☐	
SWIMMING	☐	☐	
EXERCISE	☐	☐	
OTHER	☐	☐	
OTHER	☐	☐	

INDICATE MEDICATIONS YOU ARE NOW TAKING FOR ALLERGY AND ASTHMA.
(PLEASE BRING THEM WITH YOU FOR YOUR FIRST APPOINTMENT)

	1.	2.	3.	4.	5.	6.
NAME OF MEDICATION						
DOSE OR STRENGTH						
DOSES TAKE DAILY						
SIDE EFFECTS						
DOES TAKING THIS MEDICATION HELP?	☐ NO ☐ YES ☐ SOMETIMES	☐ NO ☐ YES ☐ SOMETIMES	☐ NO ☐ YES ☐ SOMETIMES	☐ NO ☐ YES ☐ SOMETIMES	☐ NO ☐ YES ☐ SOMETIMES	☐ NO ☐ YES ☐ SOMETIMES

INDICATE NAMES OF ALLERGY OR ASTHMA MEDICINES THAT WERE TRIED BUT DID NOT WORK OR CAUSED SIDE EFFECTS

INDICATE OTHER MEDICINES OFTEN USED *(INCLUDE ASPIRIN, NOSE SPRAYS, BIRTH CONTROL PILLS, VITAMINS).*

ARE YOU ON A BETA-BLOCKER DRUG FOR YOUR HEART, BLOOD PRESSURE, EYES OR HEADACHES? ☐ NO ☐ YES | IF YES, WHICH ONE?

MEDICAL HISTORY AND APPROXIMATE DATES

HISTORY OF ALLERGY OR RESPIRATORY PROBLEMS IN INFANCY OR CHILDHOOD

☐ MILK OR OTHER FOOD ALLERGY ☐ ECZEMA ☐ ASTHMA ☐ CROUP ☐ BRONCHIOLITIS ☐ OTHER

GENERAL HEALTH
☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

WEIGHT IN THE PAST YEAR
☐ STABLE ☐ GAIN ☐ LOSS

MEDICAL ILLNESSES
☐ HEART DISEASE ☐ ARTHRITIS ☐ TB
☐ ULCERS ☐ GLAUCOMA ☐ DIABETES

CHILDHOOD IMMUNIZATIONS
☐ UP TO DATE ☐ INCOMPLETE

WERE THERE ANY UNUSUAL REACTIONS TO IMMUNIZATIONS?

OTHER MEDICAL CONDITIONS

PAST HOSPITALIZATIONS *(GIVE APPROXIMATE YEAR AND REASON)*

INDICATE OPERATIONS YOU HAVE HAD AND THE APPROXIMATE DATES

☐ TUBES IN THE EARS	☐ TONSILLECTOMY AND/OR ADENOIDECTOMY	☐ SINUS SURGERY	☐ REMOVAL OF NASAL POLYPS	☐ NASAL SEPTUM REPAIR	☐ CHEST SURGERY
DATE	DATE	DATE	DATE	DATE	DATE

SKIN

ECZEMA - WHAT MAKES IT WORSE?

HIVES AND/OR SWELLING - WHAT TRIGGERS IT?

OTHER SKIN PROBLEMS

☐ DRY ☐ SMALL BUMPY RASH ☐ ITCHY RASH ☐ EASY BRUISING ☐ REACTION TO METALS ☐ CHEMICALS ☐ COSMETICS ☐ OTHER

FOOD ALLERGIES

INDICATE FOOD(S) YOU ARE ALLERGIC TO AND THEIR REACTION(S)

ADDITIONAL FOOD ALLERGY COMMENTS *(INDICATE TYPE OF REACTION(S) AND APPROXIMATE AGE)*

DRUG ALLERGIES

☐ ASPIRIN ☐ LOCAL ANESTHETIC ☐ SULFA
☐ PENICILLIN ☐ X-RAY DYES ☐ OTHER_____

ADDITIONAL DRUG ALLERGY COMMENTS

REACTIONS TO INSECTS

☐ BEE ☐ WASP ☐ YELLOWJACKET
☐ HORNET ☐ ANT ☐ OTHER STINGING INSECT

TYPE OF REACTION

STOMACH OR INTESTINAL PROBLEMS

☐ POOR APPETITE ☐ NAUSEA ☐ ULCERS ☐ BLACK OR BLOODY BOWEL MOVEMENTS
☐ VOMITING ☐ DIARRHEA ☐ PAIN ☐ HEARTBURN ☐ OTHER_____

FAMILY ALLERGY HISTORY

	HAYFEVER OR NASAL SYMPTONS	SINUS	ASTHMA	CHRONIC LUNG DISEASE OR EMPHYSEMA	FOOD ALLERGY	HIVES OR SWELLING	ECZEMA
MOTHER	☐	☐	☐	☐	☐	☐	☐
FATHER	☐	☐	☐	☐	☐	☐	☐
BROTHERS OR SISTERS	☐	☐	☐	☐	☐	☐	☐
CHILDREN	☐	☐	☐	☐	☐	☐	☐

ARE THERE GRANDPARENTS, AUNTS OR UNCLES WITH ALLERGY PROBLEMS? ☐ NO ☐ YES *IF YES, EXPLAIN*

CHECK OR COMPLETE THE ANSWERS THAT BEST DESCRIBE YOUR HOME ENVIRONMENT

TYPE OF HOME
☐ APARTMENT ☐ DORMITORY ☐ MOBILEHOME ☐ HOUSE ☐ CONDOMINIUM

LOCATION OF HOME
☐ SEASHORE ☐ MOUNTAIN ☐ CITY ☐ COUNTRYSIDE ☐ DESERT

AGE OF HOME
AGE IN YEARS ____

IS THERE OBVIOUS?
☐ MILDEW OR WATER DAMAGE ☐ ROACHES

DO YOU HAVE?
☐ SPACE HEATER ☐ ROOM AIR PURIFIER ☐ EVAPORATIVE COOLER ☐ CENTRAL AIR CONDITIONING ☐ ROOM HUMIDIFIER ☐ CENTRAL HUMIDIFIER ☐ CENTRAL AIR PURIFIER ☐ CENTRAL HEATING ☐ FIREPLACE

BEDROOM HAS
☐ HEATING ☐ AIR CONDITIONING ☐ HUMIDIFIER ☐ AIR PURIFIER

TYPE OF BEDROOM FLOOR COVERING
☐ CARPET ☐ LINOLEUM OR TILE ☐ WOOD ☐ OTHER

BED TYPE
☐ MATTRESS AND BOX SPRING ☐ WATER BED AGE OF BED IN YEARS ____ ☐ ZIPPERED COVER ☐ MATTRESS ONLY

BEDROOM WINDOW IS
☐ OPEN ☐ CLOSED *AT NIGHT*

TYPE OF PILLOWS YOU HAVE
☐ FEATHER ☐ DACRON/SYNTHETIC ☐ FOAM RUBBER ☐ ZIPPERED COVER/PLASTIC *AGE IN YEARS* ____

TYPE OF BLANKET/COMFORTER
☐ FEATHER ☐ SYNTHETIC ☐ OTHER ____

IS THERE A SMOKER IN YOUR RESIDENCE?
☐ NO ☐ YES *IF YES, RELATIONSHIP:*

***IF YOU SMOKE,* WHERE DO YOU SMOKE?**
☐ IN HOUSE ☐ AT WORK ☐ IN CAR ☐ OUTDOORS

INDICATE INDOOR PETS YOU HAVE
☐ CAT ☐ DOG ☐ BIRD ☐ OTHER

INDICATE WHICH ANIMALS YOU ARE EXPOSED TO (OTHER THAN HOME)
☐ HORSE ☐ DOG ☐ CAT ☐ BIRD(S)

INDICATE WHERE YOU ARE EXPOSED TO PETS
☐ HOME ☐ SCHOOL ☐ DAYCARE OR BABYSITTER ☐ WORK ☐ RELATIVES ☐ PATIENT'S BEDROOM ☐ FRIENDS

INDICATE IF ANY OF THE FOLLOWING ARE OUTSIDE YOUR HOME
☐ WOOD SHEDS ☐ FIREWOOD ☐ OPEN FIELD ☐ HAY ☐ CHICKEN COOPS ☐ BARNS ☐ STABLES

DOES YOUR MOTOR HOME HAVE AIR CONDITIONING?
☐ YES ☐ NO *IF YES, DO YOU USE IT FREQUENTLY?* ☐ YES ☐ NO

ADDITIONAL COMMENTS PERTAINING TO HOME ENVIRONMENT

PAST ALLERGY EVALUATION/TREATMENT

INDICATE TYPE OF ALLERGY TESTS TAKEN BEFORE ☐ NONE ☐ BLOOD ☐ SKIN ☐ OTHER

INDICATE WHAT THE TESTS WERE POSITIVE TO ☐ POLLENS ☐ MOLDS ☐ FOODS ☐ OTHER ____ ☐ DUST ☐ ANIMALS ☐ DRUGS

HAVE YOU EVER RECEIVED CORTISONE-LIKE DRUGS (PREDNISONE, DECADRON, STEROIDS)? ☐ NO ☐ YES *IF YES, DATES* ____ *DOSE* ____ *HOW LONG?* ____

HAVE YOU RECEIVED ALLERGY SHOTS? ☐ NO ☐ YES IF YES, WHEN? *DATES FROM* ____ *TO* ____

HOW HELPFUL WERE THE SHOTS? ☐ MINIMAL HELP ☐ REACTIONS ☐ HELPFUL ☐ NO HELP

NAME AND LOCATION OF DOCTOR WHO GAVE YOU SHOTS?

IS THERE CURRENTLY AN ALLERGIST TAKING CARE OF A FAMILY MEMBER? ☐ NO ☐ YES *IF YES, INDICATE NAME AND LOCATION OF ALLERGIST*

FOR ALLERGY DEPARTMENT USE

Dr. Mark H. Schecker
Allergist

Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

Coastal Carolina Allergy and Asthma
"No Show" and "Cancellation" Policy and Procedure for Office Visits and Procedures

At Coastal Carolina Allergy and Asthma our goal is to provide quality allergy, asthma, and immunology care in a timely manner. We have implemented a no show and cancellation policy that enables us to better utilize available appointments for other patients in need of care. These appointments are in high demand. Recognizing that everyone's time is valuable, we ask that you provide at least a **24-hour notice** if you are unable to keep your appointment. Patients will be notified of this policy at the time of scheduling. It will be available on our website www.myrtlebeachallergist.com for review and can be provided in writing upon request.

Effective July 1, 2021, the policy regarding patients who do not notify us as outlined or fail to keep their scheduled office visit appointments (i.e., no-show) is as follows:

- For missed initial consultation appointments, there is a **$100 fee**.
- For all other missed appointments, there is a **$50 fee**.
- These fees will be charged to the patient, ***not their insurance company***, and is due at the time of the next appointment.
- Patients with an outstanding balance of missed appointment fees ***will not be allowed to schedule another appointment, including allergy shots, until this balance is paid in full***.
- Multiple no show appointments will result in ***dismissal from the practice***.

Please be courteous and cancel your appointments in a timely fashion, by calling (843) 293-0093. You may leave a message if there is no one in the office. We understand that emergencies and unforeseen events can occur and depending on the circumstances the missed appointment charge may be waived.

Thank you for your cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Patient Signature (Parent/Guardian if under 18)

3516 Caduceus Drive · Myrtle Beach, SC 29588
Phone: (843) 293-0093 · Fax: (843) 293-0096
www.MyrtleBeachAllergist.com

ACKNOWLEDGEMENT

I, _____ (patient), acknowledge that I have received a copy of Coastal Carolina Allergy & Asthma Associate's Notice Regarding Privacy of Personal Health Information.

Date: _____ _____

Patient's Signature

I, _____(patient) give_____

Permission to access my financial and/or private health information. This agreement will remain in effect until I notify Coastal Carolina Allergy and Asthma in writing.

_____ _____

Patient's Signature Date

Dr. Mark H. Schecker
Allergist

Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

Date _____

Dear Parent/Legal Guardian:

It is our office policy that a parent or legal guardian brings his/her child to the initial office visit, allergy testing visits and visits for certain medical procedures. We understand that circumstances may arise when another adult family member or adult friend will have to bring your child into the office for a follow up visit. In this case, we must have parent/guardian authorization to see the child.

In order for us to provide the best medical care, the adult accompanying the child must know the patient's medical history in detail. This includes a complete list of medications and dosages the child currently takes as well as the reason for the visit. In addition, the patient's primary caregiver must be available by telephone to speak with Dr. Schecker at the time of the visit.

Please Complete and sign:

I _____ parent/legal guardian authorize the following individual (s) listed below to bring my child _____ DOB _____ for treatment or allergy injections and assume responsibility for their care during this time. I also assume responsibility to notify Coastal Carolina Allergy & Asthma Associates whenever this information changes. This form shall be effective until it is canceled by the parent/legal guardian.

Parent or Guardian _____

Authorized Individuals are stated below

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

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