



Intermountain Allergy & Asthma

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The physicians and staff of Intermountain Allergy & Asthma welcome you to our practice and provide the following information to help make the time you spend in our office as comfortable as possible.

To minimize the time you must spend in our office, please complete the enclosed questionnaire and bring it with you to your appointment. If you do not complete this form at home, please arrive 30 minutes before your scheduled appointment time, as the time we have scheduled for you does not allow for completion of the questionnaire. Parental consent is necessary for medical treatment of patients under the age of 18. It is preferable to have a parent in attendance. If for some reason this is not possible, a signed consent will be required.

Please do not wear perfume, cologne, strong-smelling hair sprays, etc. to your appointment. Skin tests are usually placed on the back, so please wear clothing that may easily be removed from the waist up. ***An allergy evaluation may take 2-4 hours.*** If you can't keep your scheduled appointment, please call and cancel as soon as possible.

Certain medications such as antihistamines, allergy relief and hay fever medications, and over-the-counter nighttime pain relief or sleep aid medications can interfere with allergy testing. For this reason, we ask that you stop taking these medications prior to your appointment. ***If you have asthma, continue to take all of your regular asthma medications up to the time of your appointment.*** Continue antibiotics and all medications currently being taken for non-allergic conditions. Do not stop using nose sprays before your appointment. (If you have any concern about which medicines should or should not be taken, call our office.) Continue your usual diet.

Medicines to stop

- **3 days prior to allergy testing** - Antihistamines - Allergy relief, hay fever and cold medicines (including Benadryl), over-the-counter nighttime pain relief or sleep aid medications (such as Alka Seltzer PM, Tylenol PM, Excedrin PM, Sominex, Nytol, etc.)
- **4 days prior to allergy testing** - Allegra
- **5 days prior to allergy testing** - Claritin, Clarinex, Atarax, Vistaril, Hydroxyzine, Zyrtec
- **Hismanal and Astelin nasal spray should be discontinued IMMEDIATELY** as they can remain in your system for several weeks

Medicines to continue prior to allergy testing

- Asthma medicines
- Nasal sprays
- Inhalers
- Antibiotics
- Steroid medications such as Medrol and Prednisone
- All medications currently being taken for non-allergic conditions

Bring with you to your appointment

- Referral (if required by your insurance)
- Insurance card
- Photo identification
- Utility bill or other correspondence showing current address *if your photo identification does not include your current address.*
- Co-payment (Co-payment or 20% of billed charge is due at time of service. There will be a service charge of \$10 for all co-payments not paid at time of service. If you have any questions regarding your insurance coverage, contact your insurance company before your appointment. For non-insured [self-pay], please see enclosed Patient Financial Policy.)

Describe patient's typical symptoms: _____

SYMPTOMS (Circle all that apply)

Chest	Nose	Eyes	Throat	Skin	Ears
asthma	hay fever	itching	itching	itching	itching
cough	congestion	tearing	hoarseness	hives	blockage
wheeze	sneezing	swelling	voice loss	eczema	frequent infections
excess mucus	running	redness	frequent infections	infections	discharge
tightness	bleeding	styes	postnasal drip	swelling	hearing loss
shortness of breath	polyps	mattering	soreness		earaches
frequent infections	loss of smell		bad breath		
congestion	sinus infections		dryness		

Symptoms (circle) Year-round Seasonal Worst month _____ Best month _____

When do symptoms occur? (circle) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Which of the following appear to cause the allergy or asthma symptoms? (check)

POLLEN: trees _____ grass _____ weeds _____

ANIMAL HAIR DANDER: cats _____ dogs _____ horse _____ other furry pets or birds _____

ODORS: Christmas trees _____ detergents _____ soaps _____ hair sprays _____ paint fumes _____
tobacco smoke _____ cosmetics and perfume _____

OTHERS: temperature change _____ air conditioning _____ exercise _____ excitement _____ fatigue _____
spicy food _____ house dust _____ nighttime _____ rubber products _____ infections (colds) _____
stress _____ laughing _____ menses (periods) _____ dampness _____ aspirin _____ windy days _____

Work exposures (fumes? odors?) Include names of chemicals _____

How much school or work has been missed in the past year because of allergies or asthma? _____

Has a change in locale affected your symptoms? _____ If yes, how? _____

PREVIOUS ALLERGY STUDIES:

Have skin tests been done before? _____ Have allergy blood tests been done? _____
 Doctor _____ Date _____
 Results _____ Allergy shots? _____ When? _____
 When was the last chest x-ray? _____ Sinus x-ray? _____

MEDICATIONS: List every medication now being used (including non-allergy, non-asthma medications):

<u>Drug</u>	<u>Frequency</u>	<u>Drug</u>	<u>Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What medications have been helpful for asthma or allergies in the past? _____

Has patient used Cortisone, Prednisone, Kenalog, Decadron, or other steroids? (list): _____

MEDICATION ALLERGY: (aspirin, antibiotics, pain medicine, etc.) List drugs, reactions they cause and dates reactions occurred: _____

INSECT STING ALLERGY: List specific insect and type of reaction. _____

FOOD ALLERGY: List specific foods and describe reaction. _____

ENVIRONMENTAL CONDITIONS:

Hobbies: _____ Occupation: _____

Age of house _____ Type of construction _____ Years at present address _____

Heating system: (check)

- a. Gas _____ oil _____ electric _____ coal _____ other _____
- b. Air conditioning? Yes _____ No _____ Type _____
- c. Air filtering system? Central _____ room _____ none _____
- d. Humidifiers? Central _____ room _____ none _____
- f. Fireplace? Gas _____ Wood _____ None _____

(Please see next page)

Are there feather pillows? _____ (If yes, list where) _____

Is the basement wet, or do you see or smell mildew in the house? Yes _____ No _____

Which pets do you own? (check) dog _____ cat _____ bird _____ other _____

Are there farm animals near your home? _____ What kind? _____

Neighborhood contains: (name type if known) Trees _____

Fields _____ Farms _____

HEALTH HABITS:

a. Smoke tobacco? Yes _____ No _____ Daily amount _____ For how many years? _____

b. Do others smoke in the home? Yes _____ No _____

MEDICAL HISTORY (check all that apply):

Has patient ever had tuberculosis or a positive TB skin test _____ ulcers _____ diabetes _____ high blood pressure _____

glaucoma _____ heart disease _____ cataracts _____ cancer _____ emphysema _____ nasal polyps _____ chicken pox _____

contact lens wearer _____ heartburn _____ urinary retention _____ other diseases _____

HOSPITALIZATIONS, OPERATIONS, AND EMERGENCY ROOM VISITS:

Date

Reason

FAMILY HISTORY: If you know of allergies in any of your relatives, place check marks in the table below to show which relatives were affected by the conditions listed.

Sisters/Brothers

Mother

Father

Children

Hay fever or other nasal allergy _____

Asthma _____

Eczema _____

Hives _____

Is there a family history of any other disease or condition? List: _____

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible medical care and service to you. We regard a complete explanation of our financial policy as an essential element of your care and treatment.

We are preferred providers for many insurance companies and have agreed to accept assignment of benefits upon payment of your co-pay. Co-payment or 20% of billed charge is due at the time of service. An additional service charge of \$10.00 will be assessed if your co-payment is not made at the time of service.

Being a preferred provider for your insurance plan does not guarantee the services we provide will be covered. All health plans are not the same and do not cover the same services. It is not possible for us to know the terms of hundreds of different insurance plans and the specifics of such contractual agreements. Your insurance is a contract between you and your insurance company. It is your responsibility to know and comply with the terms of your insurance contract. In the event your health plan determines a service to be "not covered," or if payment is denied due to your failure to comply with the terms of your insurance (i.e., no referral, pre-existing condition, etc.), you will be responsible for the complete charge. **Call your health plan if you have any questions regarding your coverage.**

For all services rendered to minor patients we will look to the adult accompanying the patient and the custodial guardian for payment.

You are responsible for all collection costs incurred as a result of non-payment.

I have read and understand the financial policy of Intermountain Allergy & Asthma and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time. I further authorize the release of any medical information necessary to process my medical claims as well as payment of medical benefits to Intermountain Allergy & Asthma.

Signature

Date

Print Name

Relationship to Patient