



## Intermountain Allergy & Asthma

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6065 S. Fashion Blvd. #255  
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5929 S. Fashion Point Dr. #101 Ogden, UT 84403 (801) 476-0052 (801) 476-0064 (fax)
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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.)

**INTERMOUNTAIN ALLERGY AND ASTHMA CLINIC**

**COMPLETING YOUR PAPERWORK *PRIOR TO YOUR ARRIVAL* WILL ALLOW YOU TO BE SEEN PROMPTLY.  
ALL PAGES OF THIS QUESTIONNAIRE MUST BE COMPLETED BEFORE THE DOCTOR CAN SEE YOU.**

**PATIENT INFORMATION**

Date \_\_\_\_\_

Patient's full legal name \_\_\_\_\_  
First Middle Last

What do you like to be called? \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Personal Physician \_\_\_\_\_ Address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please list other household family members being seen at Intermountain Allergy Clinic \_\_\_\_\_

\_\_\_\_\_ By which physician \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work ph. \_\_\_\_\_ Home ph. \_\_\_\_\_ Cell ph. \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse \_\_\_\_\_ Employer \_\_\_\_\_

Spouse work phone \_\_\_\_\_ Spouse home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**INSURANCE INFORMATION**

1st Insurance \_\_\_\_\_ 2nd Insurance \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber \_\_\_\_\_

Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_

ID# \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Birthdate \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber Birthdate \_\_\_\_\_ Group# \_\_\_\_\_

Effective Date \_\_\_\_\_ Effective Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I authorize and request a summary report of this visit sent to:

Referring physician

Personal physician

None

\_\_\_\_\_  
Signature (Patient or Responsible Party)

\_\_\_\_\_  
Print Name

Describe patient's typical symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SYMPTOMS** (Circle all that apply)

<b>Chest</b>	<b>Nose</b>	<b>Eyes</b>	<b>Throat</b>	<b>Skin</b>	<b>Ears</b>
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.

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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.

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Signature

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Date

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Print Name

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Relationship to Patient

**IMPORTANT NOTICE  
REGARDING INSURANCE PLAN REQUIREMENT FOR A REFERRAL**

If your insurance carrier requires you to obtain a referral and/or authorization number from your primary care physician PRIOR to your appointment with an Intermountain Allergy & Asthma specialist, you may bring your referral with you at the time of your visit or you may have your primary care physician fax the referral to our office. Having your primary care physician fax the referral is the preferable option as that gives us time to resolve any problems that might interfere with your scheduled appointment.

If your referral is being faxed or mailed to us, please check with us a day or two before your appointment to confirm that we have received your referral. It is important that you obtain your referral well in advance of your scheduled appointment as it is difficult, if not impossible, to get authorization after you arrive at our office.

Most insurance plans will not back date a referral and pay for your visit after the fact. Therefore, if we do not have your referral prior to your appointment, you will be given the choice of rescheduling your appointment until you can obtain your referral or you can pay cash for the visit.

If you have any questions about the rules and policies of your insurance plan, contact your insurance representative promptly.

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