258 Broad Street
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ALLERGY & ASTHMA ASSOCIATES

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224 Taylors Mills Road
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New Patient History

Name: _____ DOB: _____

Referring Physician: _____

WHAT IS THE MAIN REASON FOR TODAY'S VISIT (*Please be specific*)?

CURRENT MEDICATIONS (Name/Dose/Frequency – *Please include over-the-counter medications, vitamins, oral contraceptives*):

1.	4.
2.	5.
3.	6.

DRUG ALLERGIES

Medication	Date of Reaction	Nature of Reaction

FOOD ALLERGIES

Food	Date of Reaction	Nature of Reaction

PAST MEDICAL HISTORY

- Please list **all chronic medical conditions** (ie: High Blood Pressure, Diabetes):_____

  _____
- Please list any **surgeries** you have had:_____

FAMILY HISTORY (*Please check off appropriate history*)

	Father	**Mother**	**Siblings**	**Extended Relatives**
Asthma				
Allergies (Seasonal/Food/Drug)				
Eczema				
Immune Disorder				

SOCIAL HISTORY

- Who lives in the home with you? _____
- What is your occupation? _____
  - If student, what grade are you in? _____

(OVER)

ENVIRONMENTAL HISTORY

- Do you have any pets? ☐ Cat(s) ☐ Dog(s) ☐ Bird(s) ☐ Other _____
  - If yes, are they allowed in the bedroom? ☐ Yes ☐ No
- Do you have central air conditioning? ☐ Yes ☐ No
- Do you typically keep windows in your home open, weather permitting? ☐ Yes ☐ No
- Do you have carpeting in your bedroom? ☐ Yes ☐ No
- Do you, or anyone else in your home, smoke cigarettes? ☐ Yes ☐ No
- Do you have any issues with mold/dampness in the house? ☐ Yes ☐ No
- Are your pillow and mattress new? (within past 3 years) ☐ Yes ☐ No
- Do you have dust mite encasements on your pillow/mattress? ☐ Yes ☐ No
- Are there any down/feather products in your home? ☐ Yes ☐ No

UPPER AND LOWER RESPIRATORY SYMPTOMS

NOSE	EYES	SINUS	OTHER (EAR/THROAT)
☐ Nasal Congestion ☐ Runny Nose ☐ Itchy Nose ☐ Post-Nasal Drip	☐ Red Eyes ☐ Watery Eyes ☐ Itchy Eyes	☐ Sinus Pressure/Pain ☐ Poor Sense of Smell ☐ Frequent Sinus Infections	☐ Frequent Ear Infections ☐ Hoarse voice ☐ Acid Reflux (GERD)

CHEST/LUNGS
☐ Frequent Cough ☐ Wheezing ☐ Chest Tightness ☐ Shortness of Breath ☐ Recurrent Pneumonias

- Are the above symptoms seasonal? ☐ Spring ☐ Summer ☐ Fall ☐ Winter
- Are there triggers for above symptoms? ☐ Pollen ☐ Cat/Dog ☐ Dust ☐ Mold ☐ Smoke ☐ Exercise ☐ Viral Illnesses

- Have you ever been **skin tested** before? ☐ Yes ☐ No
- Have you ever been on **allergy shots** before? ☐ Yes ☐ No
- Have you ever used a **nebulizer/inhaler** before? (*ex: Albuterol, Xopenex*) ☐ Yes ☐ No
- Have you ever smoked **Tobacco** (cigarettes)? ☐ Yes ☐ No
  - If YES, packs/day? _____ When did you start? _____ If quit, since when? _____

SKIN ISSUES

Do you have a history of:

☐ **Eczema** (*If yes, answer questions below*)

- What prescription creams/ointments have you tried? _____
  _____
- What brand soap do you use? _____
- What brand moisturizer do you use? _____

Aside from previously mentioned food/drug reactions, do you have a history of:

☐ **Recurrent Hives**

☐ **Angioedema** (swelling of body parts)

OTHER ALLERGY CONCERNS:

☐ Have you had a severe reaction in the past to a **bee/wasp/hornet/yellow jacket sting**?

☐ Have you had an allergic/adverse reaction to **Latex** products?

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Primary Physician ☐ Search Engine (*ie: Google*) ☐ Social Network/Forum (*ie: Facebook*)

☐ Friend/Current Patient_____ ☐ Other_____

(Name) (Please list)

ALLERGY & ASTHMA ASSOCIATES

www.sneezedoctornj.com

Date____ /____ /____

Patient Information

Patient Name: _____
Last First M.I.

Address:_____
Street Apt #

_____
City State Zip

Date of Birth: _____/_____/_____Race_____

Ethnicity_____ Language_____

Phone (H): _____ Phone (C): _____

SS#_____ Sex: □ Male □ Female
Marital Status: □ Single □ Married □ Divorced □ Widowed

Who referred you to us? _____

Primary Care Physician: _____

Address:_____
Street City State

Pharmacy _____
Phone

E-Mail Address:_____
(Please provide if you would like electronic copies of test results/additional information)

Patient's Employment Status

□ Employed □ Unemployed □ Retired □ Student (Full Time or Part Time)

Name of Employer_____

Address: _____

Name of School:_____

Guarantor (If other than patient, person financially responsible for payment)

Guarantor's Name: _____
Last First M.I.

Address: _____
Street Apt #

_____
City State Zip

Phone (H): _____ Phone (W) :_____

Guarantor's SS# _____ Date of Birth ____/____/_____

Employer Name:_____

Address: _____
Street Apt #

_____
City State Zip

Insurance Information

Policy #1 (Primary)

Insurance Co. Name: _____

Address:_____
Street

_____
City State Zip

Phone: _____

Policyholder's Name: _____
Last First M.I

Policyholder's Social Security # _____

Policyholder's Birth Date: _____/_____/_____

Relationship to Patient: □ self □ spouse □ parent □ guardian

Policyholder's Employer: _____

Policyholder's ID#:_____

Group#:_____ Referrals Needed: □ Yes □ No

Policy #2 (Secondary, if Applicable)

Insurance Co. Name: _____

Address:_____
Street

_____
City State Zip

Phone: _____

Policyholder's Name: _____
Last First M.I

Policyholder's Social Security # _____

Policyholder's Birth Date: _____/_____/_____

Relationship to Patient: □ self □ spouse □ parent □ guardian

Policyholder's Employer: _____

Policyholder's ID#:_____

Group#:_____ Referrals Needed: □ Yes □ No

Emergency Contact Information

Name: _____
Last First M.I.

Relationship:_____ Phone: _____

OVER →

Assignment and Release

ALL PATIENTS

I hereby assign, transfer and set over to **Allergy and Asthma Associates**, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I may be financially responsible for all charges whether or not they are covered by my insurance.

Patient's Signature: _____

Date:_____

ALL PATIENTS

I acknowledge that I have received a copy of **Allergy and Asthma Associates** notice regarding Privacy of Personal Health Information.

Patient's Signature: _____

Date:_____

ALL PATIENTS

I agree to provide accurate and current insurance information for myself or my dependent. I assume full financial responsibility for balances resulting from inaccurate and/or outdated insurance information.

Patient's Signature: _____

Date:_____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to **Allergy and Asthma Associates** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____

Date:_____

MEDIGAP PATIENTS ONLY

I request that payment of authorized Medigap benefits be made on my behalf to **Allergy and Asthma Associates** for any services. I authorize any holder of Medicare information about me to release to Allergy and Asthma Associates any information needed to determine these benefits payable for related services.

Patient's Signature: _____

Date:_____

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