

PATIENT QUESTIONNAIRE

DATE: ____/____/____

PATIENT NAME _____

Were you referred by a physician? Yes No If yes, by whom: _____

Were you referred by a friend or family member? Yes No If yes, by whom: _____

Other physicians you have seen in the past year for this problem:

1) _____ 2) _____

What is the **MAJOR PROBLEM** that prompted this visit (chief complaint)?

I. NASAL/HEAD SYMPTOMS: (If you are having HEAD OR NASAL SYMPTOMS, please fill out Section I. If not, please go to the **next section**).

- | | | |
|--------------------------------------|---|---|
| Itchy eyes <input type="checkbox"/> | Sinus infections <input type="checkbox"/> | Posterior nasal drainage <input type="checkbox"/> |
| Watery eyes <input type="checkbox"/> | Sore throat <input type="checkbox"/> | Runny nose <input type="checkbox"/> |
| Sneezing <input type="checkbox"/> | Ear pressure <input type="checkbox"/> | Itching of the throat <input type="checkbox"/> |
| Itchy nose <input type="checkbox"/> | Headache <input type="checkbox"/> | Stuffy nose <input type="checkbox"/> |
| Snoring <input type="checkbox"/> | | |

How long have you been having these symptoms? How many years? ____ months? ____

What are the **TRIGGERS** that make symptoms worse? (check all that apply)

ALLERGENS

IRRITANTS

WEATHER CHANGES

- | | | |
|---|--|--|
| <input type="checkbox"/> Mowed grass | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Windy days |
| <input type="checkbox"/> Dead grass | <input type="checkbox"/> Soaps | <input type="checkbox"/> Cold fronts |
| <input type="checkbox"/> Dead leaves | <input type="checkbox"/> Detergents | <input type="checkbox"/> Temperature Changes |
| <input type="checkbox"/> Hay | <input type="checkbox"/> Smokes | <input type="checkbox"/> Damp weather |
| <input type="checkbox"/> House dust | <input type="checkbox"/> Paint | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Hair spray | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Dogs | <input type="checkbox"/> Outside dust | <input type="checkbox"/> Time of day |
| <input type="checkbox"/> Feathers | <input type="checkbox"/> Cosmetics | |
| <input type="checkbox"/> Mold or mildew | <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other animals | Type _____ | |

Have you had previous allergy testing? Yes No _____ Results _____ Year _____ M.D.

Have you ever had allergy injections? Yes No _____ # years

IIA. CHEST SYMPTOMS: (If you are having CHEST SYMPTOMS, please fill out Section II. If not, please go to the **next section**).

What are your main CHEST symptoms? (circle answers) Cough Shortness of breath Chest infections /Bronchitis
Asthma/wheeze (go to IIB below)

How long has this been a problem? Number of years _____ number of months _____ Age at first episode _____

Triggers: When sick with colds Worse in the morning
 Exercise Worse at night
 Worse with seasons Spring Fall Summer Winter

Frequency: Daily ≥ 2 times/week ≤ 2 times/week Continuous _____ # nights per month

Treatments in the past: Inhalers Steroids Antibiotics Other _____

IIB. WHEEZING/ASTHMA: (If you are having WHEEZING OR ASTHMA, please fill out Section IIB. If not, please go to the **next section**).

How long has asthma been a problem? Number of years _____ number of months _____ Age at first episode _____

Triggers: Upper respiratory infections Exercise Nighttime Morning Non-seasonal
 Worse with seasons Spring Fall Summer Winter Pollen exposure

Frequency: Daily ≥ 2 times/week ≤ 2 times/week Continuous _____ # nights per month

Treatments tried for wheezing:

- Inhalers (names) _____
- Nebulizers (updraft) (names) _____
- Steroid shots: _____ # of times _____ # in last year
- Steroids by mouth: _____ # of times _____ # in last year

Emergency room visits needed for asthma/wheezing? _____ Total in life _____ Total in last 12 months

Hospitalizations for Asthma: _____ Total in life _____ Total in last 12 months

Intensive Care Admissions? Yes No _____ # of times Intubation: Yes No

Was birth premature? Yes No _____ weeks early NICU Ventilator x _____ days O2

Had recurrent bronchitis been a problem? Yes No _____ # of times Inhalers used? Yes No

Was the first episode of wheezing associated with RSV or a viral infection? Yes No

III. SKIN SYMPTOMS: (If you are having SKIN SYMPTOMS, please fill out Section III. If not, please go to the **next section**).

What are your skin symptoms?

Hives Eczema Itching Swelling (location _____) Rash

How long have symptoms been present? # of years _____ # of months _____ # of weeks _____

Triggers: Medications (name/date started taking) _____
 Foods (name foods) _____

Frequency of reactions? All the time daily every few days or weeks

What symptoms occur with reactions? _____

Time after ingestion _____ Treatment _____

ER visits _____

Were you given an Epi-Pen? Yes No Was an Epi-Penicillin used? Yes No

VIII. IMMUNIZATION HISTORY

Are your immunizations up to date? Yes No
Tetanus booster in last ten years? Yes No
Influenza vaccine Yes No Date last received _____
 Could not receive influenza vaccine because of Egg allergy? Yes No
Pneumonia vaccine Yes No Date last received _____

IX. FAMILY HISTORY:

ALLERGY FAMILY HISTORY:

Is there a history of any of the following in your family?

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother
Allergic rhinitis (hay fever)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother
Nasal Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother
Atopic Dermatitis (eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother
Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother
Food Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother

GENERAL FAMILY HISTORY: In your generation or the generation before you are there any of the following?

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema of the lung	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other diseases that are present in your family _____

X. PAST MEDICAL HISTORY:

GENERAL PERSONAL HEALTH HISTORY:

Have you ever had any of the following? (Insert the year)

- Anemia Yes No
- Cataracts Yes No
- Chronic otitis media (ear infections) Yes No
- Chronic sinusitis Yes No
- Congestive heart disease (heart failure) Yes No
- Coronary artery bypass graft Yes No
- Coronary artery disease Yes No
- Diabetes Yes No
- Eczema/Dermatitis Yes No
- Gallstones Yes No
- GERD (reflux) Yes No
- Glaucoma (high eye pressure) Yes No
- Headaches Yes No
- Heart disease Yes No
- Hepatitis Yes No
- Hiatal Hernia Yes No
- Hypertension (high blood pressure) Yes No
- Hypercholesterolemia (high cholesterol) Yes No
- Hypoglycemia Yes No
- Irritable bowel disease (IRB) Yes No
- Ulcerative colitis Yes No
- Migraine headaches Yes No
- Mitral valve prolapse Yes No
- Pneumonia Yes No
- Psoriasis Yes No
- Rheumatic heart disease Yes No
- Seizures Yes No
- Thyroid disease Yes No
- Tuberculosis Yes No

Cancer Yes No

Type _____

Year _____

Treatment: Chemotherapy

Radiation

Surgery

Other illnesses/diagnoses not listed: _____

HOSPITALIZATIONS:

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

SURGERIES:

Tonsillectomy Yes No Date _____

Adenoidectomy Yes No Date _____

PE tubes (ear tubes) Yes No Date(s) _____ No. of times _____

Polypectomy (nasal polyp surgery) Yes No Date(s) _____ No. of times _____

Septoplasty (nasal bone Repair) Yes No Date _____

Other surgeries: _____ Date _____

Other surgeries: _____ Date _____

Other surgeries: _____ Date _____

XI. OCCUPATIONAL/SOCIAL HISTORY:

City/state of residence: _____

Most recent occupation: _____

If a student, current grade in school: _____

Types of work done in the past: _____

Do you smoke or use tobacco products? Yes No
 Cigarettes ____ packs/day ____ number of years
 Pipes
 Cigars
 Chewing tobacco
 Snuff

Have you ever smoked tobacco in the past? Yes No ____ packs/day ____ number of years ____ year quit

Any use of marijuana? Yes No

Alcohol use None Occasional Moderate Heavy

Workplace exposures Paper dust Chemicals Other _____

XII. ENVIRONMENTAL REVIEW:

Current household members: spouse children brothers sisters parents Total No.: _____

Age of home: 0-10 years >10 years

How long at present location? 0-5 years 6-10 years >10 years

Type of home: Apartment Mobile Home House

Heat and air details: Central heat/air Window A/C
 Wood burning stove/fireplace Space heaters

Bedding details: Zipper encasings Cotton mattress/pillow Feather pillow
 hypoallergenic pillow feather comforter Feather mattress

Tobacco/smoke exposure in home: Yes No
Pets/animals (inside): Cat Dog Other _____
Pets/animals (outside): Cat Dog Other _____

XIII. Nutrition and Diet:

No food intolerances
Food intolerances (not listed above) Food _____ Symptoms produced _____
Food _____ Symptoms produced _____

Amount of milk consumed daily: None 2-3 cups 3-5 cups

XIV. TRAVEL:

- Symptoms improve when away from state
- Travel without symptoms changing

XV. PREGNANCY AND BIRTH:

Birth wt. _____ lb, _____ oz

- | | | | |
|--|------------------------------|-----------------------------|------------------------|
| Breast Fed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How long? _____ months |
| Hospital stay after birth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Numerous formula changes in the first 6-9 months of age? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Eczema less than three months of age? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| RSV before three months of age? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

XVI. PRESENT MEDICATIONS: (List here or bring a list of current medications or bring all your medications with you):

A) List all ALLERGY OR ASTHMA MEDICATIONS taken **PRESENTLY** including over-the-counter preparations, prescription tablets, oral liquids, inhalers (MDI's), nasal sprays, creams, or eye drops)

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

B) List all ALLERGY OR ASTHMA MEDICATIONS taken **in the PAST**, including over-the-counter preparations, prescription tablets, oral liquids, inhalers (MDI's), nasal sprays, creams, or eye drops)

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

C) List OTHER MEDICATIONS taken routinely or intermittently for medical reasons (i.e., vitamins, aspirin, blood pressure medications, etc)

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

XVII. SYSTEM REVIEW: Please check those symptoms you may have experienced that have NOT been mentioned above.

Comments

GENERAL

- | | | | |
|---------------|------------------------------|-----------------------------|-------|
| Appetite loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Night sweats | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Weight change | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

SKIN

- | | | | |
|---------------------|------------------------------|-----------------------------|-------|
| Dry skin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Change in wart/mole | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Itching | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

HEENT

- | | | | |
|--------------------------|------------------------------|-----------------------------|-------|
| Dry eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Glasses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Good vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Posterior nasal drainage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Clear runny nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Itching of soft palate | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Sneezing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Headache | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Excessive tearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hearing loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Ear infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Earache | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| ringing in ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Vertigo | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Nasal congestion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Sinus pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hoarseness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Oral ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Snoring | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| CPAP for Sleep Apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

NECK

- | | | | |
|----------------|------------------------------|-----------------------------|-------|
| Neck mass | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Neck pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Neck stiffness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Swollen glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

RESPIRATORY

- | | | | |
|------------------------------|------------------------------|-----------------------------|-------|
| Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Chronic cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Decreased Exercise Tolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Difficulty breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Sputum production | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Wheezing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

CARDIOVASCULAR

- | | | | |
|----------------------------------|------------------------------|-----------------------------|-------|
| Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Difficulty breathing on exertion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Fainting/blacking out | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Irregular heartbeat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Elevated blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Difficulty breathing lying down | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Rapid heart rate | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Swelling of extremities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
-

GASTROINTESTINAL

- Abdominal pain Yes No _____
- Bloody stool Yes No _____
- Constipation Yes No _____
- Diarrhea Yes No _____
- Difficulty swallowing Yes No _____
- Heartburn Yes No _____
- Indigestion Yes No _____
- Nausea Yes No _____
- Vomiting Yes No _____

MUSCULOSKELETAL

- Back pain Yes No _____
- Joint pain Yes No _____
- Joint redness Yes No _____
- Joint swelling Yes No _____
- Muscle cramps Yes No _____
- Muscle weakness Yes No _____

NEUROLOGICAL

- Dizziness Yes No _____
- Fainting Yes No _____
- Headaches Yes No _____
- Seizures Yes No _____
- Stroke Yes No _____
- Tremor Yes No _____

PSYCHIATRIC

- Moodiness Yes No _____
- Fussiness Yes No _____
- Anxiety Yes No _____
- Depression Yes No _____

ENDOCRINE

- Appetite changes Yes No _____
- Cold intolerance Yes No _____
- Excessive thirst Yes No _____
- Excessive urination Yes No _____
- Hair changes Yes No _____
- Heat Intolerance Yes No _____
- Thyroid problems Yes No _____

HEMATOLOGY

- Anemia Yes No _____
- Easy bruising Yes No _____
- Enlarged lymph nodes Yes No _____
- Nose bleeds Yes No _____

FOR OFFICE USE ONLY:

Physician Signature: _____

Date: _____



ARKANSAS ALLERGY & ASTHMA CLINIC, PA
A Tradition of Quality Patient Care Since 1930

FINANCIAL POLICY

The Arkansas Allergy & Asthma Clinic, P.A. thanks you for choosing us as your specialty health care provider. Your understanding of our financial policy is an important part of your care and professional relationship. Please ask if you have any questions regarding our fees, Financial Policy, or your responsibility.

Full payment for office visit charges is due at the time of service. We accept cash, check, money order or credit card (Visa, MasterCard, Discover and American Express). Should you need to make payment arrangements, please contact our Patient Representative before your scheduled appointment time. We will make every effort to reach mutually agreeable terms.

We are happy to answer any question you may have about the charges for your allergy care, including allergy injections.

INSURANCE

Arkansas Allergy & Asthma Clinic, P.A. files claims with all commercial insurance companies. Examples are Blue Cross Blue Shield, Medicare, Medicaid, HMO's and PPO's. **Any co-pays, deductibles, co-insurance payments, or non-covered services are your responsibility and are due at the time of service.**

If your insurance requires a referral, you are responsible for making sure a referral is obtained by the date of service. If our office does not have a referral at the time of service and your insurance does not pay, you will be responsible for the charges for services rendered.

SELF-PAY

For patients without insurance we allow a 25% discount on our fees for full payment at the time of service. Please make sure to let the cashier know that you would like to take advantage of this discount.

PAYMENT OPTIONS

Under certain circumstances, a statement may be mailed to you. All charges billed are due within 14 days of receipt of the statement. You are directly responsible for any unpaid balance on your account. If payment cannot be made when due, you must contact our Patient Representative to set up an extended payment arrangement.

We do offer the option to pre-authorize your post visit balances. We will estimate your balance and authorize your payment card for that amount. When your insurance has been adjudicated, we will then process a charge to your card for the balance, not exceeding what you have authorized. This automated process eliminates the need for us to invoice you and for you to make a future payment.

We are also able to offer payment plans for allergy shots or to patients who have high deductibles with their insurance.

After 60 days, if no payments have been made and no extended payment arrangements have been made, necessary collection efforts will begin.

In divorce cases, regardless of who has been awarded custody or financial responsibility for the child, the person bringing the child for treatment is responsible for payment of services rendered.

Arkansas Allergy & Asthma Clinic, P.A. is committed to providing you and your family with the best medical care. Our charges reflect the usual and customary fees for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of benefits.

FINANCIAL POLICY:

I have read the Financial Policy of Arkansas Allergy & Asthma Clinic, P.A. I understand that I am financially responsible for all charges whether or not covered by insurance.

X _____

Patient Signature (If under 18 years, Signature of Parent/Guardian)

Date: _____