

ALLERGY, ASTHMA AND IMMUNOLOGY CENTER – NEW PATIENT QUESTIONNAIRE

www.allergyaic.com

PATIENT NAME: _____ AGE: _____ DOB: _____

REFERRING PROVIDER: (if any) _____ REFERRING TELEPHONE: _____

PRIMARY CARE PHYSICIAN: _____ PCP TELEPHONE: _____

PHARMACY: (Please list pharmacy name and location) _____

WHO COMPLETED THIS QUESTIONNAIRE: (if other than patient) _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

CHIEF COMPLAINT(s): (Describe the reason for your visit and what problems or symptoms you are having)

WHEN DID SYMPTOMS BEGIN: _____

HOW OFTEN DO THEY OCCUR: _____

DOES ANYTHING MAKE SYMPTOMS BETTER: _____

ALLERGIC HISTORY:

Please mark any that apply to you.
This information is so that we can understand why you came to see us.

NOSE

- Itchy Nose
- Sneezing
- Runny Nose
- Stuffy Nose/Congestion
- Decreased Smell
- Post-nasal Drainage
- Sinus Infection

EARS

- Itchy Ears
- Blocked Ears

THROAT

- Sore Throat
- Hoarseness

CHEST

- Wheeze
- Shortness of Breath
- Chest Tightness
- Chest Cough

GI

- Reflux
- Heartburn

EYES

- Itchy Eyes
- Watery Eyes
- Red Eyes

SKIN

- Hives
- Rash
- Eczema
- Itching
- Swelling

HEADACHE:

Do you have headaches associated with your nasal & sinus symptoms? () Yes () No
Do you have a history of migraines? () Yes () No

FOOD REACTION:

Please list any adverse reactions you have had to foods:

INSECT REACTION:

Please list any adverse reactions you have had to insects:

FOR PROVIDER USE ONLY:

AGGRAVATING FACTORS

Please mark any factors that cause an increase in your symptoms:

Mowed Grass Hay/Dead Leaves Paint Detergents House Dust Pollen Perfumes
 Windy Days Cats Smoke Fumes Cold Fronts Dogs Outside Dust
 Hairspray Damp Weather Moldy/Musty Places Odors Soaps Temperature Changes

NONE OF THE ABOVE: _____

Do you experience allergy symptoms seasonally or year-round? () Seasonally () Year round
 If seasonally, please mark all that apply: () Spring () Summer () Fall/Autumn () Winter

TICKS

Have you ever been bitten by a tick? () Yes () No If so, when? _____
 Do you spend a lot of time outdoors? () Yes () No

STEROIDS

Have you received a steroid injection in the last six months? () Yes () No If so, when? _____
 Why did you receive a steroid injection? _____

ENVIRONMENTAL FACTORS:

What is the age of your home? () 0 – 10 years () 11 – 15 years () 16 – 20 years () More than 20 years
 How long have you lived at current residence? () 1 year or less () 1 – 5 years () 6 – 10 years () over 10 years

What type of heating/cooling system? Mark all that apply:
 Central/Forced Air Radiant Heat Ceiling Fan Window Units
 Wood Burning Gas Electric Oil/Kerosene

Please mark any of the following that are present in the patient bedroom:
 Feather Products on Bed Sleep with Stuffed Animals Carpet Hardwood

PETS:

If you have pets, what kind? Indoor: _____
 Outdoor: _____
 Do your pets sleep in bed with you? () Yes () No

PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist before? () Yes () No If so, when? _____
 Have you been skin tested? () Yes () No
 Have you ever been on allergy shots? () Yes () No If so, are you still taking them? () Yes () No
 If so, approximately how long did you take them? _____ When did you quit? _____

CURRENT MEDICATIONS:

Please list all current **ALLERGY & ASTHMA** medications you are taking regularly to relieve your allergy symptoms:

Medication	Strength	How Taking:	Reason Taking/Diagnosis:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **OTHER** medications you are taking:

Medication	Strength	How Taking:	Reason Taking/Diagnosis:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

___ Medication List Attached (See list)

List all medications or supplements you take occasionally, including dose (e.g., Tylenol, sleeping pill, etc.): _____

DRUG ALLERGIES:

Please list all medications to which you are allergic:

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

___ Others. (Please list the drug and reaction below.)

___ No known drug allergies

MEDICAL HISTORY:

Please list all significant medical problems such as Diabetes, High Blood Pressure, Heart Disease, Stomach Ulcer, Glaucoma, Seizure Disorder, Thyroid Disease, etc.:

SURGICAL HISTORY & HOSPITALIZATIONS:

Please list all hospitalizations and surgeries in order of most recent first:

	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

IMMUNIZATIONS:

Have you been vaccinated against pneumonia? () Yes () No If yes, when: _____
 Have you had a flu shot this year? () Yes () No If yes, when: _____

FAMILY HISTORY:

() Adopted/Family history is unknown.

Please mark any that apply to blood relatives.

	Hay Fever	Asthma	Sinus Problems	Immune Deficiency	Cystic Fibrosis	Hives	Eczema	Food Allergy	Auto-immune Disease
Father	()	()	()	()	()	()	()	()	()
Mother	()	()	()	()	()	()	()	()	()
Siblings	()	()	()	()	()	()	()	()	()
Children	()	()	()	()	()	()	()	()	()
Other	()	()	()	()	()	()	()	()	()

SOCIAL HISTORY:

How many people are living at home? _____

Marital Status (if patient minor/child, leave blank): _____

What are your favorite hobbies? _____

Employment:

Where are you employed (or attend school)? _____

Job description? _____

Does anything at work or school bother your allergies? _____

Number of days missed from work/school per year because of allergy, sinus or asthma problems? _____

If patient is a child, does he/she attend day care? _____

If yes, how many days per week? _____

TOBACCO USE / EXPOSURE:

Indicate any that are true for the patient:

____ Current Smoker ____ Former Smoker ____ Nonsmoker ____ Uses Vape ____ Uses smokeless tobacco or nicotine patches

____ Smokers/Vapers in the home (smoke indoors) ____ Smokes in car or parent smokes in car ____ Chews Tobacco

If current or former smoker, please complete next section:

How many years have you smoked? _____

How many packs per day? _____

Have you ever quit as long as 6 months? (please explain) _____

If you have smoked in the past, what year did you stop smoking? _____

How many years did you smoke and how much? _____

PLEASE READ IMMEDIATELY

Seven-day Medicine Restriction Prior to Skin Testing/First Visit

To achieve accurate skin test results, you must **avoid certain medications for 7 days**; otherwise, we will not be able to determine your allergens accurately and will have to reschedule your appointment.

DO NOT TAKE THE FOLLOWING MEDICATIONS FOR 7 DAYS PRIOR TO YOUR SKIN TESTING OR FIRST APPOINTMENT. If you have any questions or if you cannot safely avoid these medicines for the seven-day duration, please contact us as soon as possible.

DRUG NAME	GENERIC NAME
Alavert/Claritin/Claritin D/Clarinet	Loratadine
Allegra/Allegra D	Fexofenadine
Atarax/Vistaril	Hydroxyzine
Doxepin	Sinequan
Zyrtec/Zyrtec D/Xyzal	Cetirizine/Levocetirizine
Antivert	Meclizine
Astelin Nasal Spray	Azelastine
Axid	Nizatidine
Brovex	Brompheniramine
Dymista	Azelastine/Fluticasone
Ryaltris	Olapatadine/Mometasone
Patanase	Olopatadine
Pediox	Carbinoxamine
Periactin	Cyproheptadine
Pepcid	Famotidine
Phenergan	Promethazine
Tavist	Clemastine
Tagamet	Cimetidine
Allergy/Antihistamine Eye Drops: prescription or over-the counter, i.e., Visine A, Naphcon A, Optivar, Elestat, Patanol	
All over-the-counter antihistamines, cough, cold and sleep medication, i.e. Tylenol P.M., Advil P.M., Benadryl, Zantac	



Questions or concerns? Please call our office:

866-983-2242

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO AAIC

Patient Name: _____ DOB: _____

Patient Phone Number: _____ SSN (last 4): _____

Patient Address: _____

I am authorizing and requesting that copies of my medical records be RELEASED from:

Name of Provider/Clinic/Organization:	Provider Phone:
Provider Fax Number:	Provider Address:

I would like my records to be released by (check one):

Mail Fax

For the reason of (check all that apply):

Personal Request by Patient
 Continuity of Medical Care

Insurance Carrier Request
 Attorney or Legal Request

Workers Compensation
 Other (please describe)

To be released to:

Name of Provider/Clinic/Organization: Allergy, Asthma & Immunology Center	Provider Phone: 865-273-0008
Provider Fax Number: 865-336-8404 (ATTN: Medical Records)	Provider Address: 616 W Lamar Alexander Pkwy Maryville, TN 37801

I AUTHORIZE the following information to be disclosed (check any that apply, or check ALL records):

Any and ALL records

Records regarding treatment for the following condition(s): _____

Records covering the date range of _____ to _____

I understand that I have the right to revoke this authorization in writing at any time by sending written notification to the Privacy Officer, Allergy, Asthma & Immunology Center, 6701 Baum Dr, Ste 140, Knoxville, TN 37919. I understand that I have the right to refuse to sign this form and my refusal will not result in AAIC conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this form, if it is for disclosure of information created for research that includes treatment, may result in AAIC declining to provide the research-related treatment. 2. Refusal to sign this release, if it is for disclosure of information to a third-party, may result in AAIC declining to provide healthcare which for the sole purpose of creating protected health information for disclosure to a third party. I understand this authorization will expire in one-year time from the signing of this form. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE SIGNATURE

DATE