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/Clarinex	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	Brompheniranine
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

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:

______________________ Provider Signature

______________________ Date

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? _____________________

Chart #: ___________________ Date: ________

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.:

____

____

____

____

____

____

Chart #: ___________________ Date: _______

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? ____________________

Allergy, Asthma & Immunology Center (AAIC)
Phone: 865-273-0008   Fax: 865-895-4090

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