AGGARWAL ALLERGY & ASTHMA CLINIC

Pediatric and Adult Allergy and Asthma

Belton
17067 S 71 Hwy
Belton, MO 64012

Main Office
600 NW Murray Rd, Suite 306
Lee's Summit, MO 64081
816-525-8400
816-525-8411 (Fax)
www.KCPOLLEN.com

Gladstone
101 NW Englewood Rd.
Gladstone, MO 64118

Blue Springs
104 N 7 Hwy
Blue Springs, MO 64014

NEW PATIENT APPOINTMENT INSTRUCTIONS

PLEASE USE RED OR BLUE INK ON ALL PAGES

Antihistamines must be discontinued prior to Allergy Testing. Some antihistamines may need to be discontinued five (5) days prior to the visit. These include Claritin, Allergra, Zyrtec, Xyzal and Clarinex.

Benadryl and some of the older antihistamines need to be discontinued 2-3 days only.

In addition to allergy and cold/cough medications; many over the counter sleep aids, anti-nausea, antidepressants, and sedative medications frequently contain antihistamines.

Asteline, Astepro and Patanase nose sprays will need to be discontinued 48 hours prior to Allergy Testing. No need to stop steroid nose sprays.

Optivar, Pataday, Patanol, and Bepreve eye drops will need to be discontinued 48 hours prior to Allergy Testing.

If you are not sure if the medications you are taking contain antihistamine, check with your pharmacy.

DO NOT STOP ASTHMA MEDICATION (INCLUDING SINGULAIR)

Bring a complete list of all medications you are taking, along with the strength and dose.

Bring a list of all of your drug and food allergies

Bring a summary of your medical history, surgeries, hospitalizations, etc. This will greatly expedite the evaluation process and assures complete and accurate health information.

Arrive 15 minutes prior to your scheduled appointment time to fill out paperwork.

Bring your current insurance card (s).

Bring a Photo ID with your current mailing address. If your Photo ID does not have your current address on it, please bring a utility bill that has been mailed to your current address.

You will be required to pay your copays, co-insurance and any deductible at the time of service unless prior arrangements have been made.

Bring any referrals required by your insurance plan.

AGGARWAL ALLERGY & ASTHMA CLINIC

PATIENT INFORMATION

NAME (FIRST) _____ (MI) _____ (LAST) _____ DOB _____ AGE _____

MARITAL STATUS: S M W D SEX: M / F SS# ___-___-___ HOME # ( )_____ CELL # ( )_____

ADDRESS _____ CITY _____ ST _____ ZIP _____

EMP & OCCUPATION _____ WORK # ( ) _____

PERSONAL EMAIL _____

REFERRED BY _____ PHONE # ( ) _____

SPOUSE'S NAME _____ DOB _____ SS # ___-___-___

EMP & OCCUPATION _____ WORK # ( ) _____ CELL # ( )_____

IF PATIENT IS A MINOR

FATHER'S NAME _____ DOB _____ SS# ___-___-___

EMP & OCCUPATION _____ WORK # ( )_____ CELL # ( ) _____

MOTHER'S NAME _____ DOB _____ SS# ___-___-___

EMP & OCCUPATION _____ WORK # ( ) _____ CELL # ( )_____

RESPONSIBLE PARTY _____ SS# ___-___-___

ADDRESS _____ CITY _____ ST _____ ZIP _____

DOB _____ SEX: M / F HOME # ( ) _____ CELL # ( ) _____

EMP & OCCUPATION _____ WORK # ( )_____

DO YOU HAVE AN HRA / HSA ACCOUNT? YES / NO. IF YES, HOW MUCH IS LEFT?

PRIMARY INSURANCE HMO OR PPO COPAY _____	SECONDARY INSURANCE HMO OR PPO COPAY _____
INSURANCE CO _____	INSURANCE CO _____
ID# _____	ID# _____
GROUP # OR NAME _____	GROUP # OR NAME _____
SUBSCRIBER NAME _____	SUBSCRIBER NAME _____
SUBSCRIBER DOB _____	SUBSCRIBER DOB _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____
SUBSCRIBER ADDRESS _____	SUBSCRIBER ADDRESS _____
EFFECTIVE DATE _____	EFFECTIVE DATE _____

I request that all payments authorized by Medicare/Insurance benefits on my behalf be paid to Aggarwal Allergy Clinic, Inc. for all services rendered to me. I authorize Aggarwal Allergy Clinic, Inc. to release my medical information to my Insurance Company listed above, and to their agents in order to determine any benefits payable for related services.

I understand services for which I am treated may or may not be covered by my insurance Company or Medicare. I am aware that I can be billed and I am responsible for any existing or remaining balance after all mandatory adjustments have been made to my account.

_____ _____ _____

SIGNATURE/PATIENT OR GUARDIAN RELATIONSHIP TO PATIENT DATE

AGGARWAL ALLERGY & ASTHMA CLINIC
Pediatric and Adult Allergy and Asthma

Name _____ DOB _____ Age _____ Date _____

Do you have ALLERGIES? Yes ☐ No ☐ ASTHMA? Yes ☐ No ☐ FOOD ALLERGIES? Yes ☐ No ☐

(Spring) (Fall)
Circle the symptomatic months: Jan Feb Mar Apr May Jun July Aug Sept Oct Nov Dec Year-round symptoms How long? _____ Months _____ Years.

What treatment have you received for Allergies or Asthma? _____

_____

_____

_____

ROS: Check Symptoms ☑ (Please be as complete as possible)

Eyes: ☐Itching ☐Burning ☐Redness ☐Watering ☐Swelling ☐Shiners (dark circles under eyes) ☐Dryness ☐Discharge ☐Visual problems

Ears: ☐Itching ☐Pain ☐Infections ☐Tubes (years) _____ ☐Popping ☐Hearing loss ☐Fullness

Nose: ☐Itching ☐Sneezing ☐Congestion (Worse: ☐AM ☐PM ☐All day) ☐Drainage (color _____)
☐Postnasal drip ☐Snoring ☐Runniness ☐Apnea ☐Blood ☐Decreased smell Year of last sinus X-ray ____

Throat: ☐Soreness ☐Redness ☐Itching ☐Mucus ☐Throat clearing ☐Hoarseness ☐Bad breath

Resp: ☐Cough (worse in the: ☐AM ☐PM ☐All day) ☐Cough wakes patient up at night (# of times waking up _____).
Cough is: ☐Dry ☐Moist (Color of discharge _____) ☐Cough is worse with exercise.
☐Cough is worse with laughter ☐Cough is worse with crying Cough is worse ☐Lying down (or) ☐Upright
☐Wheezing Year of last Chest X-ray _____ Results of last Chest X-ray _____

CV: ☐Tightness in the chest ☐Shortness of breath ☐Chest pain (Location) _____

GITract: ☐Heartburn/stomach reflux: Worse: ☐AM ☐PM ☐After meals ☐All day ☐Heartburn/reflux makes the cough worse
☐ Hiatal Hernia ☐ Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Pain (Frequency _____)

Const: ☐ Headache: ☐ Dull ☐ Throbbing ☐ Pressure ☐ Migraine
Location of Pain or Pressure _____
☐ Fatigue ☐ Dizziness ☐ Night sweats ☐ Fever

Skin: ☐Eczema ☐Rash ☐Hives ☐Swelling ☐Itching ☐Dry Skin (Location) _____.

All/Imm: Insect reactions to: ☐ Bees ☐ Wasps ☐ Hornets ☐ Fire ants ☐ Mosquitoes ☐ Chiggers
Reaction Type: ☐Large local swelling ☐Hives ☐Wheezing ☐Throat swelling ☐Nausea/diarrhea
☐ Unconsciousness ☐Emergency treatment required _____. Age at time of reaction _____.

Mus/Skel: ☐ Joint pain ☐ Joint swelling

Gen/Urine: ☐ Blood in the urine ☐ Foamy urine ☐ Painful urination ☐ Incontinence

AGGARWAL ALLERGY & ASTHMA CLINIC

Patient's Name _____ **DOB** _____

Date _____

PRECIPITATING FACTORS/TRIGGERS

	ALLERGY				ASTHMA			
	Condition made worse	Condition improved	No change		Condition made worse	Condition improved	No change
Cutting or playing in grass Raking leaves	☐	☐	☐	Animal	☐	☐	☐
High winds	☐	☐	☐	Colds or viruses	☐	☐	☐
Other outdoor exposure	☐	☐	☐	Exercise	☐	☐	☐
Moldy/mildewed area (basement, attic)	☐	☐	☐	Cold weather	☐	☐	☐
Dusting or vacuuming	☐	☐	☐	Emotional stress	☐	☐	☐
Air conditioning or heating	☐	☐	☐	Menstruation	☐	☐	☐
Cleaning agents, soaps detergents, etc.	☐	☐	☐	Foods (Please list) _____	☐	☐	☐
Paint, motor fumes,	☐	☐	☐	Smoke Exposure	☐	☐	☐
Cigarette smoke	☐	☐	☐	Other _____			

Risk Factors

Tobacco Use? ☐ current ☐ previous ☐ never Year Started _____ Year Stopped _____

Cigarettes _____ pack/day Cigar _____ # per week Smokeless/chewing _____# per day

Passive Smoke Exposure? ☐ yes ☐ no Alcohol use? ☐ yes ☐ no

Caffeine use? Drinks per day _____

Exercise? Times per week? _____

Patient Name: _____ **DOB** _____ **Date:** _____

PAST MEDICAL HISTORY: Have you ever had any of the following?

Cancer	Yes	No
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Pancreatic	☐	☐
Brain	☐	☐
Ovarian	☐	☐
Prostate	☐	☐
Tumor	☐	☐
Other	☐	☐

_____

Heart Disease	Yes	No
Stroke	☐	☐
Hypertension	☐	☐
High Cholesterol	☐	☐

Ears, Nose & Throat	Yes	No
ENT Problems	☐	☐
Eye Disease	☐	☐
Hearing Impaired	☐	☐

Skin	Yes	No
Skin Disease	☐	☐
Dysplastic Moles	☐	☐

Musculoskeletal	Yes	No
Arthritis	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Chronic back pain	☐	☐
Growth disorder	☐	☐

Endocrine	Yes	No
Diabetes	☐	☐
Thyroid disease	☐	☐
Autoimmune disorder	☐	☐
Kidney disease	☐	☐

Respiratory	Yes	No
Respiratory disease	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic lung disease	☐	☐

Neurological	Yes	No
Neurological disease	☐	☐
Epilepsy	☐	☐
Chronic Headaches	☐	☐

Psych/Social	Yes	No
Psychiatric illness	☐	☐
Depression	☐	☐
Suicide Attempt	☐	☐

Other

_____
_____
_____
_____

SURGICAL HISTORY: Have you ever had any of the following (Please circle all that apply to the patient)

Cardiac
Cardiovascular Surgery
Valvular
Peripherial vascular Surgery

EENT
Ear Tubes
Cataract Surgery
Eye Surgery
Sinus Surgery
Septoplasty
Tonsillectomy

Lung
Lung Surgery

Musculoskeletal Surgery
Orthopedic Surgery
Cervical Laminectomy
Lumbar Laminectomy
Back Surgery
Shoulder Surgery
Foot Surgery
Knee Surgery

GU Surgery
GU Surgery
Renal Surgery
Prostrate Surgery
Vasectomy

GI Surgery
GI Surgery
Ulcer Surgery
Appendectomy
Colectomy
Gall Bladder
Hernia Surgery
Hemorrhoidectomy

GYN Surgery
C-Section
Uterine Surgery
Lumpectomy
Mastectomy
Breast Reduction
Hysterectomy
Ovary Removal
Tubal Ligation

Other Surgery
Neurological
Thyroid
Hematological

_____
_____
_____

AGGARWAL ALLERGY & ASTHMA CLINIC

Name _____ **DOB** _____ **Date** _____

IMMUNIZATIONS UP TO DATE ☐ Yes ☐ No

List Reactions, if any _____

Patient's Social History

What is your occupation? _____ **Place of Employment** _____

Who do you live with? _____ **Marital Status? S M D W**

Spouses Name: _____ **Number of Children?** _____

Environmental History

Where do you live? (Circle one)
House Condo Apartment Mobil Home

Yrs in this residence? _____
How old is structure? _____ **Yrs**

Any rooms damp or dusty? _____

Type of Heating? _____
Type of Air Conditioning? _____

Type of Flooring in Bedroom? _____ **How old?** _____
Type of Flooring in Living Room? _____ **How old?** _____

Indoor Plants? ☐ none ☐ few ☐ many **Are there Smokers in the house?** ☐ No
☐ Yes/outside only
☐ Yes/inside

Stuffed Toys? _____
Do you have Pets? _____
Please list what types, how many and location (outdoors, indoors – not in bedroom, occasionally in bedroom, sleeps in bedroom, previously in home) _____

_____

Do you use? ☐ Attic fan ☐ Electronic air filter ☐ Dehumidifier

Pillows? ☐ Feather with allergy encasement
☐ Feather without allergy encasement
☐ Synthetic with allergy encasement
☐ Synthetic without allergy encasement

Mattress? ☐ Foam with allergy encasement
☐ Foam without allergy encasement
☐ Innerspring with allergy encasement
☐ Innerspring without allergy encasement

Age of Pillows? _____ **Yrs.** **Age of Mattress?** _____ **Yrs.**

Is there a down comforter in the room? ☐ Yes ☐ No
List all occupational/recreational exposures? _____

_____

ONLY FOR PATIENTS WITH HIVES AND SWELLING

Patient Name _____ **DOB** _____ **Date** _____

SKIN HISTORY:

Hives and/or rash and/or swelling/angioedemia:

Features: **Date of onset** _____ **worse in: ☐AM ☐PM☐ all day ☐after meals**

☐ Itching present
Affected areas: **☐arms ☐hands ☐legs ☐feet ☐stomach ☐back**
☐ head/face ☐Tongue/Lips

Appearance: **☐red ☐ flat ☐raised ☐blistery ☐ leaves marks/bruises ☐hives/rash move around ☐hives/rash stay in one spot. How long do the hives/rash last?** _____
hives or rash is described as ☐mild ☐moderate ☐severe

How frequent are Episodes? _____. **Does it affect your airways?** _____.

Triggers: **☐heat ☐exercise ☐sunlight ☐cold ☐water ☐pressure ☐vibration ☐rubbing/scratching**
☐contact (what material/plant/food/animal/cosmetics? _____.

☐menstrual cycle/hormones ☐stress ☐food (which ones? _____.

☐infections/colds/flu ☐medication (which one? _____.

☐New medications _____.

☐New foods _____.

Personal articles: soap _____ **shampoo** _____ **conditioner** _____

detergent _____ **fabric softener** _____ **toothpaste** _____

Moisturizer _____ **cosmetics** _____

What treatment has been given? _____

_____

_____

_____

_____

_____

_____

AGGARWAL ALLERGY & ASTHMA CLINIC

CURRENT MEDICATION LIST

Today's Date _____

Patient's Name _____ DOB _____

List DRUG Allergies _____

_____

List FOOD Allergies _____

_____

PLEASE LIST ALL MEDICATIONS ALONG WITH THE STRENGTH & DOSAGE

NAME OF PRESCRIPTION MEDICATION	STRENGTH	DOSAGE

PLEASE LIST ALL NON-PRESCRIPTION MEDICATIONS (OVER THE COUNTER)

NAME OF NON-PRESCRIPTION MEDICATION	STRENGTH	DOSAGE

AGGARWAL ALLERGY & ASTHMA CLINIC, INC.

VERIFICATION " RECEIPT" OF PRIVACY PRACTICES

I have received a copy of AGGARWAL ALLERGY & ALLERGY CLINIC, INC. PRIVACY PRACTICES

_____ _____

(Print Patient Name) **(Date of Birth)**

_____ _____

(Patient Signature) - or Guardian **(Date)**

This upper portion will be signed only after you arrive at the office and receive the PRIVACY PRACTICE
****

APPROVED PATIENT COMMUNICATION LIST

In Accordance With Aggarwal Allergy Clinic, Inc. Privacy Practices, I hereby authorize Aggarwal Allergy Clinic, Inc. to communicate with the following people regarding my care (for example: spouse, children, parent, other relative, friend, case manager, etc.) If none, please write "none".

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

May we contact you at work (if adult)? YES OR NO

I may revoke any or all of these authorizations at any time upon written notification to Aggarwal Allergy Clinic, Inc.

_____ _____ _____

(Signature) **(Printed Name)** **(Date)**