ALLERGY, IMMUNOLOGY & ASTHMA MEDICAL GROUP

Office use only

DATE______________ DOCTOR____________________ ACCT#____________ E-SCRIPT_________

PATIENT FINANCIAL INFORMATION

M____ F____

CHILDS NAME____ HOME PHONE #______________________

Last, First Middle Initial

DOB: _______-_________-________AGE________CELL_______________________EMAIL______________________

MAILING ADDRESS____

Number and Street City, State, Zip Code + 4 digit postal code

REFERRED BY _______________________________FAMILY DOCTOR____________________________________

Any other family members patients?____

SPOUSE OR RESPONSIBLE PARTY

FATHERS NAME____

ADDRESS :____

If different from above Number and Street City, State, Zip Code+4 digit postal code

DOB _______/______/______________SOCIAL SECURITY #_____________/_________/__________________

EMPLOYER____PHONE____________________________

BUSINESS ADDRESS____

Number and Street City, State, Zip Code + 4 digit postal code

MOTHERS NAME____

ADDRESS IF DIFFERENT ABOVE____

DOB:______/______/_______________SOCIAL SECURITY #_____________/_________/__________________

EMPLOYER____PH0NE______________________________

BUSINESS ADDRESS____

INSURANCE INFORMATION

PRIMARY INS____________________________________INSURED'S NAME___________________________________

SECONDARY INS__________________________________INSURED'S NAME___________________________________

If the child has insurance through a step-parent/guarantor provide the following information

NAME_____________________________________DOB____________________SOC SEC#_________________

ADDRESS____PHONE_________________________

EMPLOYER__________________________________PHONE__________________________RELATION___________

EMERGENCY CONTACT____

PHONE_______________________________________RELATIONSHIP_______________________________________

Preferred Pharmacy____Location_____________________________

I authorize the release of any medical information necessary to process this claim and authorize payment of medical benefits to undersigned physician or supplier for service described. I understand and agree that I am responsible for the balance of my account for any professional services rendered.

Signature____Date___________________

Allergy, Immunology & Asthma Medical Group, Inc.

The medications listed below must be stopped prior to skin testing. Please review this list and locate any medications you are currently taking and stop them for the period of time indicated. Please be aware than many over the counter medications have antihistamine in them and would interfere with skin testing.

If you have any questions about a medication or if you feel you cannot safely stop the medication please call the office at 951-5353

If you cannot withhold your medication prior to your visit
DO NOT RE-SCHEDULE YOUR APPOINTMENT

Stop 24 hours prior to testing	Stop 72 hours prior to testing	Stop 7 days prior to testing		
Antacids Axid (nizatidine) Tagamet (cimetidine) Pepcid (famotadine) Zantac (ranitidine) Nasal Sprays Nasal sprays are OK to use EXCEPT: Astelin, Patanase and Astepro Stop Astelin, Patanase or Astepro at least 48 hours prior to your visit Asthma Meds Ok to use prior to your visit Eye Drops stop 72 hrs prior to testing **Patanol, Pataday, Optivar, Naphcon A, Vasocon A, Elestat, Zaditor, Bepreve, Ophcon A**, LASTACAFT	<u>Stop all Allergy, Cold, Cough or Sinus meds or any med that contains antihistamines</u> Actifed Advil PM Antivert Bonine Bromfed Benadryl (diphenhydramine) Chlortrimeton (chlorpheneramine) Deconamine Dramamine Excedrin PM Meclazine Naldecon Pannaz PBZ Periactin Phenergan Polyhistine, Polyhistine D Promethazine Rynatan, Semprex, Semprex D Sudafed Allergy Tavist, Tavist D Trinalin Triaminic Tylenol Allergy Tylenol PM Tylenol Cold & Sinus Unisom All Cold and Nighttime meds	Adapin Advil Allergy Ah-Chew Alavert Allegra Allegra D Allerhist Allertan Allerx Amitriptyline Anafranil Asendin Atarax Atrohist Aventyl BC Cold Bentyl Benztropin Biohist Carbinoxamine Cetirizine Claritin Clarinex Clarinex D Clemastine Clomipramine Cogentin Comtrex Contac Coricidin Cyproheptadine	Desipramine Dimetapp Doxepin Dramamine Drixoral Durahist Duratan Duravent Dytan Elavil Etrafon Extendryl Fexofenadine Imipramine Limbitroir Lodrane Loratadine Ludiomil Marezine Norpramin Nortriptyline Nyquil Pamelor Pedicare Pediatan Polyhist Protriptyline Remeron Rescon Resperidone Risperdal	Robitussin Cough, Cold & Allergy Rondec Rutuss Ryna Ryneze Seroquel Sinequan Singlet Sominex Surmontil Tacaryl Tandur Tavist Temaril Therafin Tofranil Triavil Trimipramine Vicks Vivactil Zonolon Zyrtec Zyrtec D Xyzal

Allergy, Immunology & Asthma Medical Group, Inc.
4628 Georgetown Place
Stockton, CA 95207
209 951-5353

Name:____ **Date:**____________

Complete this form and bring it with you to your first appointment.
Bring ALL of the medications you are currently taking to your first appointment

Describe your symptoms

Allergy	
Asthma	
Other Symptoms	

Please complete for all medications you are currently taking

Medication Name	Dosage / How often per day	Reason you take this medication

List any medications you are allergic to	**Describe the allergic reaction**

List any other medical problems you have	**List any surgeries that you have had**

Smoking History:

Do you currently smoke? ☐ No ☐ Yes...... How many packs per day: ______

Have you smoked in the past? ☐ Yes ☐ No

How many years have you smoked? ________

If you stopped smoking, when did you stop? ________

How many packs did you smoke per day? ______

Do you work? ☐ No ☐ **Yes, what is your job** ________________________

Are you a student? ☐ **No** ☐ **Yes**

List any sports activities that you are involved in: ________________________

Indicate the medical history for your family members

Family Member	**Medical History** *(i.e. cancer, heart problems)*	**Asthma** *(yes or no)*	**Allergies** *(yes or no)*	**Emphysema or COPD** *(yes or no)*
Mother				
Father				
Children				
Siblings *(brothers/sisters)*				

Answer the following questions about your home:

Type of flooring: ☐ carpet ☐ wood ☐ vinyl ☐ tile

Type of heating unit: ☐ central ☐ wall heater ☐ wood burning stove

Type of cooling unit: ☐ central ☐ wall ☐ water cooler ☐ other ______

Does your heating and cooling unit use filters? ☐ Yes ☐ No

Do you have pets? ☐ Yes ☐ No

	No	Yes	How many pets do you have?	Are your pets mostly inside or outside?
Do you have cats?				
Do you have dogs?				
Do you have birds?				
Do you have hamsters?				
Do you have other pets ? What kind:				

Does your home have mold damage? ☐ Yes ☐ No

Do you sleep with the windows open? ☐ Yes ☐ No

Do you use any feather or down bedding? ☐ Yes ☐ No