ALLERGY, IMMUNOLOGY & ASTHMA MEDICAL GROUP

Office use only E-SCRIPT_____

DATE_____DOCTOR_____ACCT#_____ M ___F____

PATIENT FINANCIAL INFORMATION

PATIENT'S NAME _____
Last First Middle Initial

DATE OF BIRTH _____-_____-_____AGE _____

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

HOME PHONE_____CELL_____Email _____

SOCIAL SECURITY #_____-_____-_____EMPLOYER_____

BUSINESS ADDRESS_____PHONE# _____
Number and Street City, State, Zip Code + 4 digit postal code

REFFERED BY: _____FAMILY DOCTOR:_____

Any other family members patients?_____

Patient, circle appropriate one: **Single** **Married** **Separated** **Divorced** **Widowed**

SPOUSE OR RESPONSIBLE PARTY

NAME _____RELATIONSHIP_____

DOB ____/_____/_____SOC SEC#_____

EMPLOYER_____PHONE_____

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

INSURANCE INFORMATION

PRIMARY INS_____INSURED'S NAME_____

SECONDARY INS_____INSURED'S NAME_____

We are required to maintain the privacy of your health information (HIPAA). Please advise who we may disclose your information to:
Name_____Relationship_____

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

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

Stop 72 hours prior to testing

Stop all Allergy, Cold, Cough or Sinus meds or any med that contains antihistamines

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

Stop 7 days prior to testing

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