

ALLERGY, IMMUNOLOGY & ASTHMA MEDICAL GROUP

Office use only

E-SCRIPT _____

DATE _____ DOCTOR _____ ACCT# _____ M ___ F _____

PATIENT FINANCIAL INFORMATION

PATIENT'S NAME _____

DATE OF BIRTH _____ - _____ - _____ Last First Middle Initial
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

REFERRED 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	Stop 72 hours prior to testing	Stop 7 days prior to testing			
<p>Antacids Axia (rifaxidine) Tagamet (cimetidine) Pepcid (famotidine) Zantac (ranitidine)</p> <p>Nasal Sprays Nasal sprays are OK to use EXCEPT: Asthin, Patanase and Astepro</p> <p>Stop Astelin, Patanase or Astepro at least 48 hours prior to your visit</p> <p>Asthma Meds OK to use prior to your visit</p> <p>Eye Drops stop 72 hrs prior to testing Patanol, Pataday, Optivar, Naphcon A, Vascon A, Iclevat, Zaditor, Bepreve, Ophcon A, LASTACAF</p>	<p>Stop all Allergy, Cold, Cough or Sinus meds or any med that contains antihistamines</p> <p>Actifed Advil PM Artvert Bonine Bromfed Benadryl (diphenhydramine) Chloritrameton (chlorpheniramine) Dexonamine Dramamine Eccedrin PM Meclazine Naldecon PABAR PEZ Periacin Phebergan Polyhistine D Pronethazine Rynatan Semprex, Semprex D Sudafed Allergy Tavis, Tavis D Triadin Triaminic Tylenol Allergy Tylenol PM Tylenol Cold & Sinus Unison All Cold and Nighttime meds</p>	<p>Adapin Advil Allergy Adv-Cher Alavert Allegra Allegra D Allephist Alerstan Alerx Amiripryline Anadant Asendin Atarax Atrahist Aventyl BC Cold Benyl Benzitropin Biobist Carbinoxamine Celizine Claritin Clarix Clarimex D Clemastine Clemipramine Cogentin Comtrex Contac Cortadin Cyrproheptadine</p>	<p>Desipramine Dimetapp Doxepin Dramamine Drixoral Durahist Durzatan Duravent Dylan Elavil Etraxon Extendryl Fexofenadine Imipramine Lambitrol Lodrane Loratadine Ludionil Marezine Norpramin Norprytine Nyquil Panselor Pedicare Pediatan Polihist Proprityline Rameron Rescon Resperitone Risperdal</p>	<p>Robitussin Cough, Cold & Allergy Rondac Rutiss Ryna Ryneze Seroguel Sinequan Singlet Somnex Saramonth Tacerol Tandar Tavis Temeril Therain Tofranil Triavil Triaminpramine Vicks Vivacil Zonobon Zyrtec Zyrtec D Xyzal</p>	

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