Texas Allergy Center
Allergy relief you can rely on

214-370-5700

PATIENT INFORMATION FORM

All information provided on this form is confidential. We appreciate your cooperation in filling out this form with complete and accurate information. Thank you!

PLEASE PRINT CLEARLY

Patient Information:

Patient Name: _____ Date of Birth: _____ Sex: M or F

Home Address: _____ Marital Status: S M W D City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Employer (if applicable): _____ Occupation: _____

Whom may we thank for referring you to us? _____

If the patient is a MINOR or under LEGAL CONSERVATORSHIP, please provide the following information: Parent/Legal Guardian Name: _____ Date of Birth: _____

Home Address: _____ Sex: M or F

City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

EMERGENCY CONTACT (if different than above):

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Primary Physician's Name: _____ Address: _____ Tel: _____

Preferred Pharmacy's Name: _____ Address: _____ Tel: _____

INSURANCE INFORMATION

Name of Insurance: _____

Primary Subscriber's Name: _____ Subscriber's DOB: _____

Policy/Subscriber #: _____ Group #: _____

I authorize and consent to examination and treatment as deemed necessary to the patient by Jane Lee, M.D., and the medical staff. I authorize the release of medical information necessary to process medical claims. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered (co-pay, co-insurance, and deductibles). I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

_____ _____

Patient/Guardian Signature **Date**

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NOTICE OF PRIVACY PRACTICES

I _____(patient/guardian name) acknowledge receiving a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that a copy of any amended Notice of Privacy will be available at each appointment.

□ If you would like to receive a copy of any amended Notice of Privacy Practices by e-mail, please provide your email address here: _____

Patient Name (please print): _____

Guardian Name and Relationship (if applicable): _____

Patient/Guardian Signature: _____ **Date:** _____

Yo_____(Paciente/Guardian) reconozco que he recibido una copia del Aviso de esta Práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificada estará disponible en cada cita.

□ **Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por correo electronico**

a: _____

Paciente:_____

Firmado: _____**Fecha:**_____

Si no está firmada por el paciente Imprimir Nombre de

Guardian/Padre/tutor:_____

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OSHA PRESCREENING FOR AEROSOL TRANSMISSIBLE DISEASE

Please complete this form and initial where indicated.

Tuberculosis: ***Please indicate if you have any of the following symptoms:***
If NONE, please initial here: _____

□ Productive Cough
□ Bloody Sputum
□ Malaise
□ Fever
□ Night Sweats
□ Unexplained Weight Loss

Influenza and Other Aerosol Transmissible Diseases (Including *Pertussis, Measles, Mumps, Rubella, Chicken Pox, and Meningitis*): ***Please indicate if you have any of the following symptoms:***
If NONE, please initial here: _____

□ Body Aches
□ Runny Nose
□ Sore Throat
□ Nausea
□ Vomiting
□ Diarrhea
□ Fever
□ Severe Coughing Spasms
□ Painful/Swollen Glands
□ Skin Rash/Blisters
□ Stiff Neck

Chronic Respiratory Diseases (Non-infectious and Non-Aerosol Transmitted Disease; These diseases do not disqualify a patient from treatment): ***Please indicate if you have any of the following:***
If NONE, please initial here: _____

□ Bronchitis
□ Emphysema
□ Allergies
□ Asthma
□ Chronic Upper Airway Cough Syndrome (Postnasal Drip)
□ Gastroesophageal Reflux Disease (GERD, Acid Reflux)
□ Chronic Obstructive Pulmonary Disease (COPD)

_____ _____
Patient Name (please print) **Guardian Name (if applicable, please print)**

_____ _____
Patient/Guardian Signature **Date**

HEALTH CHANGES	SIGNATURE	DATE

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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB**:_____ **Today's Date**: _____

Reason for Today's Visit: _____

_____ **When did it start?** _____

REVIEW OF SYSTEMS

Please circle the symptoms that you find troublesome:

GENERAL	HEAD	EAR	EYES	NOSE	THROAT	RESPIRATORY	GI	SKIN
FEVER	HEADACHE	EARACHES	ITCHY WATERY RED EYES	SNEEZING ITCHY	SORE THROAT	WHEEZING	ABDOMINAL PAIN	HIVES
CHILLS	SINUS PAIN	CLOGGED EARS	BLURRED VISION	RUNNY NOSE	DIFFICULTY SWALLOWING	COUGH	BLOATING/ EXCESSIVE GAS	SWELLING
FATIGUE	RECURRENT SINUS INFECTION	HEARING PROBLEMS	DOUBLE VISION	NASAL CONGESTION	EXCESSIVE SNORING	SHORTNESS OF BREATH	HEARTBURN	ECZEMA
NIGHT SWEATS	DIZZINESS	EAR DRAINAGE	VISION CHANGES	NOSE BLEEDING	HOARSENESS	SHORTNESS OF BREATH BY EXERCISE	NAUSEA/ VOMITING	SKIN RASH
WEIGHT GAIN	SINUS PROBLEMS	RECURRENT INFECTION	DARKNESS UNDER EYES	NOSE DISCHARGE	RECURRENT INFECTION	CHEST TIGHTNESS	INDIGESTION	PERSISTANT ITCHY
WEIGHT LOSS		RINGING OR POPPING	DRY EYES	LOSS OF SMELL	MOUTH BREATHING	RECURRENT PNEUMONIA	OTHER	
OTHER:					LOSS OF TASTE	PHLEGM		

Do you miss work or school because of your symptoms? NO / YES, how many days per month? ____ **Do you have any learning or behavioral problem(s)?** NO / YES, what type of problem(s)?_____

Please circle your symptom triggers:

OUTDOOR	INDOOR	FOODS	DRUGS	CONTACT	OTHER
Temp. Change	Dust	Milk	Aspirin	Wool	Emotion/Stress
Wind	Perfume	Seafood	Penicillin	Cosmetics	Laughing
Weather	Animal	Nuts	Sulfa		Exercise
Pollens	Smoke				Colds/Flu
Smog	Mold	Other (please list):	Other (please list):	Other (please list):	
	Work Place				
	Hobbies				

What is your worst season? Winter / Spring / Summer / Fall

When is the worst time of day? Morning / Afternoon / Evening / Night

Have you seen an allergist before? NO / YES

If YES…

Who was your previous Allergist? _____

Have you had allergy skin testing before? No Yes, when? _____

Have you had allergy blood testing? No Yes, when? _____

Have you had allergy shots before? No Yes, when? _____

Were allergy shots helpful? No Yes

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PAST MEDICAL HISTORY

Do you have any of the following Allergy & Immunology conditions? (please circle)

Allergic Rhinitis / Hay Fever	Urticaria (Hives)	Food Allergies
Asthma	Angioedema (Swelling)	Others (please list):
Eczema	Contact Dermatitis	

Please list any additional medical conditions:

_____

Have you ever been hospitalized?

Date: _____ Reason: _____

Date: _____ Reason: _____

Have you ever had surgery?

Date: _____ Reason: _____

Date: _____ Reason: _____

DIETARY HISTORY (only for children 2 years and under)

Breast feeding? NO / YES, until what age? _____

Formula feeding? NO / YES, what type? MILK / SOY / HYPOALLERGENIC / AMINO ACID / OTHER

Baby food starting at what age? _____

Solid food starting at what age? _____

History of food intolerance? NO / YES, to what foods? _____

MEDICATION HISTORY

Do you have any DRUG ALLERGIES? NO / YES

If yes, please list the specific drug(s) and your reaction(s): _____

_____

Circle all medications you are currently taking: (Please list medications for other medical conditions)

Asthma:	**Allergic Rhinitis:**	**Others (please list):**
Flovent / QVar / Pulmicort	Allegra / Claritin / Zyrtec / Xyzal	
Asmanex / Arnuity	Benadryl / Atarax	
Advair / Symbicort / Dulera / Breo	Sudafed / Afrin	
Albuterol / Ventolin / Proventil	Flonase / Rhinocort / Nasacort	
ProAir / Xopenex	Nasonex	
Spiriva	Azelastine	
Atrovent / Combivent	Dymista	
Singulair / Zyflo		
Prednisone / Medrol		

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ENVIRONMENTAL EXPOSURES

(Please circle all that apply)

Home: House / Apartment

Flooring: Carpet / Wood / Linoleum

Ventilation: Forced air / Heating / Air Conditioning

Do you have any pets? NO / YES, what type? _____

If no, are you frequently exposed to any pets? NO / YES, what type? _____

Do you smoke? NO / YES, how many packs per day? _____

If NO, are you frequently exposed to smoke? NO / YES

SOCIAL HISTORY

Occupation:_____ **Hobbies:**_____

Do you drink alcohol? NO / YES, what type of alcohol and how much/often? _____

FAMILY HISTORY

(Please check all that apply.)

	FATHER	MOTHER	CHILDREN Son / Daughter	SIBLINGS Sister / Brother	FATHER'S PARENTS	MOTHER'S PARENTS
Hay Fever			/	/		
Asthma			/	/		
Eczema			/	/		
Food Allergy			/	/		
Sinus Problems			/	/		
Migraine			/	/		