

# ALLERGY AND ASTHMA CLINIC, PC

*Christina M. Abraham, MD*

Patient's name \_\_\_\_\_ Date \_\_\_\_\_ MR# \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email: \_\_\_\_\_

Sex male / female Race \_\_\_\_\_ Marital Status \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work phone \_\_\_\_\_ ext \_\_\_\_\_

Parent or Guardian's Names (if Minor) \_\_\_\_\_ Employers of parents \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_

Spouses name \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's work phone \_\_\_\_\_ ext \_\_\_\_\_ Spouse's social security # \_\_\_\_\_

In case of Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Family Physician (PCP) \_\_\_\_\_ Referred by \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ Relationship \_\_\_\_\_

***Please give a copy of the insurance card to the secretary for us to photocopy.***

Primary holder on insurance: Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

## **Please read before signing**

A copy of the Notice of Privacy Practices is posted for review. Please sign below.

Date \_\_\_\_\_ Signed \_\_\_\_\_

I hereby authorize Allergy and Asthma Clinic, PC to release information to my insurance company. I hereby assign and direct payment to Allergy and Asthma Clinic, PC. of the benefits herein specified and otherwise payable to me but not to exceed the doctor's regular charges for this treatment or surgical procedures. I understand I am financially responsible to the corporation for charges/charged amounts not covered by this agreement.

Date \_\_\_\_\_ Signed \_\_\_\_\_

Virginia State law provides that when a healthcare worker is exposed to the body fluids of another person in a manner which may transmit human immunodeficiency virus (HIV-the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to the testing for HIV and to the release of the results to the exposed person and to the local health department.

Date \_\_\_\_\_ Signed \_\_\_\_\_

By becoming a patient of Allergy and Asthma Clinic, PC. and presenting myself for appointment with the physicians or nurse practitioners, I consent and authorize treatment by the qualified care providers of Allergy and Asthma Clinic, PC. Qualified care providers include but are not limited to the physicians, nurse practitioners, phlebotomists, nurses, etc. I hereby agree that the care providers may examine me, perform non-invasive diagnostic tests and treatment to be performed.

Date \_\_\_\_\_ Signed \_\_\_\_\_

**Allergy and Asthma Clinic, PC**

**New patient questionnaire**

Patient's name \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age \_\_\_\_\_

For what sorts of problem are you consulting the doctor for today?

\_\_\_\_\_

When did your condition begin? \_\_\_\_\_ Have you seen an allergist before? Yes / No Who? \_\_\_\_\_ When? \_\_\_\_\_  
Where skin tests done? Yes / No Did you receive allergy shots? \_\_\_\_\_

What other medical or emotional problems are you being treated for?

\_\_\_\_\_

What surgeries have you had? \_\_\_\_\_

What medications do you take? \_\_\_\_\_

\_\_\_\_\_

Do you have any drug allergies? \_\_\_\_\_

Do you have HIV or AIDS, Hepatitis B, Hepatitis C, or any other blood transmitted disorders? \_\_\_\_\_

What is your profession? \_\_\_\_\_ Marital status? \_\_\_\_ Did you ever smoke? Yes / No Do you still smoke? Yes / No  
Number of years smoked \_\_\_\_ Year quit \_\_\_\_ Are you exposed to second hand smoke? Yes / No How much alcohol do you  
drink? \_\_\_\_\_ Other drugs? \_\_\_\_\_

Do you live in: house, apartment, trailer Year built? \_\_\_\_ BASEMENT? None / Damp / Dry What kind of heat do you  
have? \_\_\_\_\_ Type of air conditioning? \_\_\_\_\_ Do you have pets? \_\_\_\_\_ What kind of pets do you have?  
\_\_\_\_\_ Is your bedroom tile, hardwood, carpet? \_\_\_\_\_

**Do you have any of the following problems? Please circle all that apply**

Allergy: Bee sting reaction beyond a local reaction, food allergy, recurrent sinus infections requiring antibiotics

Constitutional: anorexia, chills, fatigue, fevers, malaise, sweats, weight loss

ENT: ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia (trouble swallowing)

Eyes: blurring, diplopia (double vision), discharge, eye pain, irritation, photophobia, vision loss

Respiratory: cough, dyspnea (shortness of breath), excessive sputum, hemoptysis (cough up blood), wheezing

GI: abdominal pain, change in bowel habits, constipation, diarrhea, hematochezia (blood in stool), jaundice, melena (dark black tarry stool), nausea, vomiting

Cardiovascular: chest pains, palpitations, syncope, orthopnea (trouble breathing when sleeping flat), peripheral edema

Genitourinary: pain on urination, blood in urine, incontinence

Musculoskeletal: arthritis, back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness

Skin/Integumentary: dryness, itching, rash, suspicious lesions

Neurological: paresthesias, seizures, syncope, transient paralysis, tremors, vertigo, weakness

Psychiatric: depression, anxiety, hallucinations, mental disturbance, paranoia, suicidal ideation

**I authorize that the information on this page is true to the best of my knowledge.**

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_