Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Reece A. Jones, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN

NORTHERN NEVADA ALLERGY

8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701
775-826-4900 • FAX 826-3257 • www.nevallergy.com

Hello,

Thank you for scheduling your initial office visit with us. We ask that you check in 15 minutes prior to your appointment time.

Please allow yourself plenty of time to carefully complete our Allergy History Questionnaire.

Please plan on arriving on time for your appointment. If you arrive late or have not completed your questionnaire, we will need to reschedule your appointment.

Because we are a specialist, we ask that you call your insurance before arriving for your appointment in order to check your benefits for allergy testing and treatment.

We may be able to perform allergy testing at this appointment depending on time allowed in our schedule and your insurance coverage. In order to be prepared for this possible testing, please refrain from taking any medication containing an antihistamine for five (5) days prior to your appointment.

Please don't hesitate to call me if you have any questions or if I can help in any way. We are looking forward to seeing you.

Sincerely yours,

Northern Nevada Allergy Staff

Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Reece A. Jones, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN

NORTHERN NEVADA ALLERGY

8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701
775-826-4900 • FAX 826-3257 • www.nevallergy.com

Welcome to Northern Nevada Allergy

In an effort to serve you better, it is important that you understand that it is your responsibility:

- to know your insurance,
- to know if Northern Nevada Allergy is a contracted provider for your insurance,
- to know if you need **prior authorization** for procedures or office visits,
- to know if procedures such as allergy injections, allergy skin testing, etc. are covered under your insurance,
- to know if you have a **copayment** and/or **yearly deductible**,
- to know how much of your deductible has been met.

There are hundreds of insurance companies and plans within those companies, and it is not possible for our staff to know the specific requirements of each policy.

Please help us better serve you.

_____
Patient's Name (Please print)

_____ _____
Signature of patient/legal guardian Date

Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Reece A. Jones, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN

NORTHERN NEVADA ALLERGY

8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701

INFORMED CONSENT TO DIAGNOSE AND TREAT

ALL FORMS OF MEDICAL TREATMENT CARRY RISKS OF POSSIBLE SIDE EFFECTS, INCLUDING BODILY HARM OR EVEN DEATH. RISKS ASSOCIATED WITH ALLERGY DIAGNOSIS AND TREATMENT ARE DECREASED WHEN THE PROCEDURES ARE DONE BY EXPERIENCED PERSONNEL UNDER THE GENERAL SUPERVISION OF AN ALLERGIST, RISKS ARE INCREASED WHEN UNSUPERVISED ADMINISTRATION OF VACCINES AND/OR INCORRECT OR EXCESSIVE USE OF MEDICATIONS ARE UNDERTAKEN. WITHOUT TREATMENT, ALLERGIES THEMSELVES HAVE THE POTENTIAL TO CAUSE EQUALLY SEVERE REACTIONS.

I, THE UNDERSIGNED PATIENT (OR PARENT/GUARDIAN OF A PATIENT WHO IS A MINOR OR UNABLE TO GIVE LEGAL CONSENT), HAVE READ THE ABOVE AND UNDERSTAND IT. I DO HEREBY AUTHORIZE ANY DIAGNOSTIC PROCEDURE, INCLUDING, BUT NOT LIMITED TO, HISTORY TAKING, PHYSICAL EXAMINATIONS, LABORATORY TESTS, ALLERGY SKIN TESTING, PULMONARY FUNCTION TESTING, NASAL AND PHARYNGEAL ENDOSCOPY, AND EAR FUNCTION TESTING; AND ANY MEDICAL TREATMENT INCLUDING, BUT NOT LIMITED TO, ALLERGEN IMMUNOTHERAPY VACCINE ADMINISTRATION, MEDICATIONS, DIETARY RESTRICTIONS, AND EMERGENCY TREATMENT DEEMED ADVISABLE BY JEFFREY S. NUGENT, M.D. OR MARIA R. REYES, M.D., WHETHER DIRECTLY ADVISED AND/OR RENDERED BY DOCTOR NUGENT, DOCTOR REYES OR BY OTHER QUALIFIED OFFICE STAFF UNDER THEIR GENERAL SUPERVISION.

_____
Patient's Name (please print)

_____ _____
Signature of Patient (or Legal Guardian) Date

_____ _____
Witness Date

Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Reece A. Jones, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN

8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701

FINANCIAL POLICY

Thank you for choosing Northern Nevada Allergy to participate in your medical care. In an effort to provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

All patients are financially responsible for services provided by Northern Nevada Allergy Clinic (NNA).

- NNA requires that you provide a copy of your current insurance card and photo ID at **every visit**.
- It is the patient's responsibility to know their insurance policies, terms, conditions and limitations.
- As a requirement of both NNA and your insurance company, co-payments are due at the time of service. If you are unable to make your co-payment, you will be assessed a $25 processing fee.
- Payment of co-insurance or any charges not covered by your plan is required at the time of service.
- Medicare recipients are expected to update the National File with any changes by calling 1-800-MEDICARE.
- Payment is required in full at the time of service from uninsured patients unless arrangements have been made in advance.
- If previous arrangements have not been made, any account balance over 90 days will be turned over to a collection agency.
- A fee of $25 will be charged to you for returned checks, plus any bank fees incurred.

Appointments

- A $35 fee will be assessed for your second non-testing appointment canceled without 24 hours notice.
- Patients who accumulate a total of three "No Shows" in a calendar year may be terminated from the practice.
- For all testing procedures lasting four hours and longer, we require a $50 deposit to hold your appointment block. We require 48 hours cancellation for all testing appointments; failure to give 48 hours notice will result in the forfeiting of your $50 deposit.

Referrals/Authorizations

- It is the patient's responsibility to ensure that any referrals or authorizations for treatment are provided to the office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of your visit.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about our Financial Policy should be directed to the front desk personnel.

I have read and understand the Financial Policy and agree to comply and accept responsibility for services provided by Northern Nevada Allergy.

_____ _____

Signature of financially responsible party Date

_____

Printed Name

Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Reece A. Jones, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN

NORTHERN NEVADA ALLERGY

8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of your protected Health Information

Your protected health information will be used by Northern Nevada Allergy Clinic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Northern Nevada Allergy Clinic may or may not agree to restrict the use of disclosure of your protected health information.

If Northern Nevada Allergy Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to change Privacy Practices

Northern Nevada Allergy Clinic reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and the Notice of Privacy Practice (if requested) for Northern Nevada Allergy Clinic. I give my permission to use and disclose my health information in accordance with it.

_____

Person(s) to have access to my notes, etc.

_____

Name of Patient (Please print)

_____ _____

Signature of patient/guardian Date

WELCOME TO NORTHERN NEVADA ALLERGY CLINIC, LTD.
THE FOLLOWING INFORMATION IS NECESSARY FOR BILLING AND COLLECTION
THIS FORM NEEDS TO BE UPDATED ANNUALLY

PATIENT INFORMATION

FIRST NAME_____ MI _____ LAST NAME_____

DOB_____ SSN _____ GENDER: □ MALE □ FEMALE

MAILING ADDRESS _____

CITY, STATE _____ ZIP _____

May we leave a detailed message regarding your medical care / treatment at this number?

HOME PHONE _____ □ YES □ NO

CELL PHONE _____ □ YES □ NO

WORK PHONE _____ □ YES □ NO

E-MAIL _____

EMPLOYER _____OCCUPATION_____

EMPLOYER PHONE _____

MARITAL STATUS:
□ SINGLE
□ MARRIED
□ DIVORCED
□ SEPARATED
□ WIDOW(ER)
□ DOMESTIC PARTNER

RACE (REQUIRED):
□ AMERICAN INDIAN OR ALASKA NATIVE
□ ASIAN
□ BLACK OR AFRICAN AMERICAN
□ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
□ WHITE
□ REFUSE TO REPORT

ETHNICITY (REQUIRED):
□ HISPANIC OR LATINO
□ NON HISPANIC OR LATINO
□ REFUSE TO REPORT

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE _____ DOB _____

PHARMACY INFORMATION

PHARMACY OF CHOICE _____

ADDRESS/LOCATION (e.g. N MCCARRAN & PRATER) _____

MISCELLANEOUS INFORMATION

WHO REFERRED YOU TO OUR OFFICE? _____

MEDICAL INSURANCE INFORMATION
PLEASE BE PREPARED TO SHOW YOUR INSURANCE CARD AND IDENTIFICATION AT EVERY OFFICE VISIT

PRIMARY INSURANCE COMPANY_____

POLICYHOLDER'S NAME_____ DOB_____ SSN _____

POLICY/ID NUMBER _____ GROUP # _____

PATIENT'S RELATIONSHIP TO POLICYHOLDER: □ SELF □ SPOUSE □ CHILD □ OTHER _____

SECONDARY INSURANCE COMPANY_____

POLICYHOLDER'S NAME_____ DOB_____ SSN _____

POLICY/ID NUMBER _____ GROUP # _____

PATIENT'S RELATIONSHIP TO POLICYHOLDER: □ SELF □ SPOUSE □ CHILD □ OTHER _____

The above information is true to the best of my knowledge. I authorize Northern Nevada Allergy Clinic to release my information to insurance carriers concerning my medical condition/treatment, etc. in order to facilitate claims payment.

_____
PATIENT NAME (PLEASE PRINT)

_____ _____
PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Reece A. Jones, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN

8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701
775-826-4900 • FAX 826-3257 • www.nevallergy.com

Date:_____

Patient's Name: _____ Date of Birth:_____
First Middle initial Last

Gender:_____ Age: _____ Marital Status:_____ Occupation: _____ City of Residence:_____

Who / How were you referred to our practice? _____

Who is your Primary Healthcare Physician/Provider? _____

Person completing this form, if other than patient: _____ /_____
Relationship to patient

Would you like medical records from your evaluation with us sent to: ☐ Primary Care provider above ☐ Referring provider above ☐ Other: _____

What is the main problem that has brought you in for evaluation?

How long ago did these symptoms FIRST BEGIN?

What treatments have you tried?

What helped the most?

DRUG ALLERGIES: List, or write "none"

MEDICATIONS:
First, please list medications taken for any <u>ALLERGY-RELATED</u> (Respiratory, nasal, eye, skin, etc) conditions:

Medication Name	Dosage:	Times per day:	How long used:	Effectiveness:

ALL other medications, or herbal supplements taken for ANY OTHER CONDITIONS: (include over-the-counter / as needed):

Symptoms and Contributory History

NOSE AND SINUSES:	**None**	**Mild**	**Moderate**	**Severe**	Remarks:
Itchy nose	☐	☐	☐	☐	
Rubbing the nose	☐	☐	☐	☐	
Sneezing	☐	☐	☐	☐	
Stuffy nose / nasal congestion	☐	☐	☐	☐	
Runny or drippy nose	☐	☐	☐	☐	
Drainage into throat	☐	☐	☐	☐	
Thick or thin?					
Frequent throat clearing	☐	☐	☐	☐	
Sleeping with mouth open	☐	☐	☐	☐	
Snoring	☐	☐	☐	☐	
Decreased sense of smell	☐	☐	☐	☐	
Rate your sense of smell from 0-10: (0 being none, and 10 being normal): _____ out of 10					
Facial pressure or pain	☐	☐	☐	☐	
Headache	☐	☐	☐	☐	
Itchy / scratchy throat	☐	☐	☐	☐	
Lump or "frog" in throat	☐	☐	☐	☐	
Thick green or yellow nasal mucus	☐	☐	☐	☐	
Hoarseness	☐	☐	☐	☐	
Loss of voice	☐	☐	☐	☐	
History of broken nose / nasal trauma?	☐ No		☐ Yes		
Recurrent sinus infections?	☐ No		☐ Yes		
Frequency:					
CT (cat scan) of the sinuses?	☐ No		☐ Yes		
Ever told you have Nasal Polyps?	☐ No		☐ Yes		
CT (cat scan) of the sinuses?	☐ No		☐ Yes		
Have you been evaluated previously by an ENT (Ear, Nose, Throat) Doctor?	☐ No		☐ Yes		
Who?					
Details					
Last seen:					
Previous nasal or sinus surgery?	☐ No		☐ Yes		
Details:					
Tonsils or adenoids removed?	☐ No		☐ Yes		Which/ when:
EYES:					
Itchy eyes or rubbing of eyes	☐	☐	☐	☐	
Burning eyes	☐	☐	☐	☐	
Watery eyes	☐	☐	☐	☐	
Red / Bloodshot eyes	☐	☐	☐	☐	
Swelling around eyes	☐	☐	☐	☐	
Darkness under eyes	☐	☐	☐	☐	
Eyelids stick together	☐	☐	☐	☐	
DO YOU WEAR CONTACTS:	☐ No		☐ Yes		
Last eye exam:					
Ophthalmologist?					
EARS:					
Itching of ear canals or outer ear	☐	☐	☐	☐	
Ear stuffiness, fullness or pressure	☐	☐	☐	☐	
Ear popping or clicking	☐	☐	☐	☐	
Difficulty "clearing ears"	☐	☐	☐	☐	
Decreased hearing acuity	☐	☐	☐	☐	
Dizziness / Vertigo	☐	☐	☐	☐	
Ear infections? Frequency, details:					
Ear surgery or tubes? When, details:					

LUNGS / BREATHING:	**None**	**Mild**	**Moderate**	**Severe**	Remarks:
Cough	☐	☐	☐	☐	
Wheezing	☐	☐	☐	☐	
Shortness of breath	☐	☐	☐	☐	
Chest Tightness	☐	☐	☐	☐	
Are these symptoms CONTINUOUS Or do they occur in EPISODES?	☐ Continuous		☐ Episodes		
Do the above symptoms limit your activity level?	☐ No		☐ Yes		How often:
Do these symptoms wake you at night?	☐ No		☐ Yes		How often:
Have you been diagnosed with asthma?	☐ No		☐ Yes		
Have you been diagnosed with COPD, emphysema, or chronic bronchitis?	☐ No		☐ Yes		
Are you currently using any inhalers or nebulizers to help you breathe easier?	☐ No		☐ Yes		
Have you used any inhalers in the past?	☐ No		☐ Yes		
Have you been given oral steroids for breathing symptoms (ie Prednisone, Medrol)	☐ No		☐ Yes		How often: Last given:
Have you required Emergency Room care for breathing symptoms?	☐ No		☐ Yes		How often: Last ER visit:
Have you been hospitalized for breathing symptoms?	☐ No		☐ Yes		How often: Last Hospitalized:
Have you had any pulmonary function (breathing) testing?	☐ No		☐ Yes		Details:
Have you ever had a Chest Xray?	☐ No		☐ Yes		
Last done:	Findings:				

SKIN / RASHES	None	Mild	Moderate	Severe	Remarks:
Hives (red, raised, itchy blotches)	☐	☐	☐	☐	
Swelling of the skin	☐	☐	☐	☐	
Eczema / Atopic dermatitis	☐	☐	☐	☐	
Contact dermatitis	☐	☐	☐	☐	
Itching WITHOUT any rash	☐	☐	☐	☐	
Other rash / not sure	☐	☐	☐	☐	
Does it itch?	☐ No		☐ Yes		
Does it burn or hurt?	☐ No		☐ Yes		
Are there bumps?	☐ No		☐ Yes		
Are there blisters?	☐ No		☐ Yes		
How long has it been present	____ days	_____ weeks	_____ months		
Is this a CONTINUOUS rash or does it come and go in EPISODES?	☐ Continuous		☐ Episodes		
How long to individual lesions last?	____ hours	_____ days	_____weeks		
Where does the rash START?					
What body part(s) are affected?					
Do any of the following make the rash worse:					
Dry Skin?	☐ No		☐ Yes		
Heat (ie hot tubs, heaters)?	☐ No		☐ Yes		
Exercise?	☐ No		☐ Yes		
Cold?	☐ No		☐ Yes		
Foods?	☐ No		☐ Yes		List:
Any relation to meals?	☐ No		☐ Yes		
Medications?	☐ No		☐ Yes		
Other triggers you suspect:					

Have you seen any other dermatologist or allergist for this?	☐ No	☐ Yes	Who? Last seen?
If Yes- what evaluation was done?			
What treatments have you tried?			
☐ Antihistamines- less sedating: (Claritin, zyrtec, allegra, etc)		Effectiveness:	
☐ Antihistamines- sedating: (benadryl, atarax/hydroxyzine,etc)		Effectiveness:	
☐ Topical Steroids (triamcinolone, mometasone, etc)			
☐ Protopic ointment or Elidel cream		Effectiveness:	
☐ Other: list:		Effectiveness:	
Have you received **oral** steroids (ie Prednisone or medrol) for this?	☐ No	☐ Yes	Response: Last taken: Number of times taken:
Have you received **a steroid shot** (ie kenalog, depo-medrol) for this?	☐ No	☐ Yes	Response: Last taken: Number of times taken:
Other information you feel is relevant:			

FOOD ALLERGIES:			Remarks:
Do you have any known or suspected food allergies:	☐ No	☐ Yes	If YES, list the foods, and the reactions below:
FOOD #1: _____			
Reaction:			
How treated:			
Eaten since?			
FOOD #2:_____			
Reaction:			
How treated:			
Eaten since?			
FOOD #3:_____			
Reaction:			
How treated:			
Eaten since?			
Avoiding any foods in your diet now?	☐ No	☐ Yes	Which ones:
Do you have an EPIPEN or TWINJECT (auto-injectable epinephrine device)?	☐ No	☐ Yes	

STINGING INSECT ALLERGY:			
Do you have any known or suspected allergies to stinging insects (ie bees/ wasps / yellow jackets?):	☐ No	☐ Yes	If YES, list the reactions below:
How long ago were you stung?			
What stung you (if known?):			
Where were you stung?			
Reaction / Treatment:			
Were you ever allergy tested for this?			
Other relevant information?			
Do you have an EPIPEN or TWINJECT (auto-injectable epinephrine device)?	☐ No	☐ Yes	

TRIGGERS: Which of the following make your symptoms worse? Mark all that apply

	Nasal, Ear, or Eye symptoms	Breathing symptoms	Skin symptoms	Remarks:
Worse indoors	☐	☐	☐	
Worse outdoors	☐	☐	☐	
Grass	☐	☐	☐	
leaves / mulch / compost / hay	☐	☐	☐	
Cats	☐	☐	☐	
Dogs	☐	☐	☐	
Other animals (specify) _____	☐	☐	☐	
Upper respiratory infections	☐	☐	☐	
Tobacco smoke	☐	☐	☐	
Strong odors or perfumes	☐	☐	☐	
Chemical vapors or aerosol sprays	☐	☐	☐	
Dust	☐	☐	☐	
Weather changes / humidity changes	☐	☐	☐	
Cold air	☐	☐	☐	
Stress or strong emotions	☐	☐	☐	
Exercise	☐	☐	☐	
Sunlight or sun exposure	☐	☐	☐	
Alcohol ingestion	☐	☐	☐	
Cosmetics- specify:	☐	☐	☐	
Foods- specify:	☐	☐	☐	
Relation to menstrual cycle	☐	☐	☐	
Taking NSAID medications such as Motrin (ibuprofen/advil), naprosyn or aspirin? Have you taken any of these before? How often / last taken:	☐	☐	☐	
Other triggers : (specify)	☐	☐	☐	
Seasons: Spring	☐	☐	☐	
Summer	☐	☐	☐	
Fall	☐	☐	☐	
Winter	☐	☐	☐	
ALL YEAR	☐	☐	☐	

Have you been previously tested for allergies?

If YES: Year_____ City _____ Doctor _____

- ☐ Skin tested for environmental allergies: (Findings):
- ☐ Blood tested for environmental allergies:(Findings):

- ☐ Skin tested for food allergies (Findings):
- ☐ Blood tested for food allergies (Findings):

- ☐ Patch tested for contact dermatitis (Findings):

Have you been on allergy shots?

If YES: When were you started on shots?
How long were you on shots?
Last received? Did they help?
Did you have any reactions to the shots?

SMOKING HISTORY:

___ Never Smoked
___ In the past, but I quit → # years smoked:_____ # packs per day _____ When did you quit? _____
___ I Currently Smoke: → # years smoked:_____ # packs per day _____

ALCOHOLIC BEVERAGE HABITS:

HOUSING / ENVIRONMENT: Check the things that are true about your home:

	Type of Building:		**Heating and Cooling:**		**Your BEDROOM:**
☐	Single family home	☐	Radiators	☐	Carpeted
☐	Apartment/ condo/ dormitory	☐	Central forced heating	☐	Hard floor (wood, tile, etc)
☐	Mobile home	☐	A/C- central forced air	☐	Curtains
☐	Farm / Ranch	☐	A/C- window unit(s)	☐	Feather or down comforter
☐	Mainly wall-to-wall carpet	☐	Humidifiers used	☐	Have dust mite-proof covers on pillows
☐	Mainly hard-surface flooring	☐	DE-humidifiers used	☐	Have dust mite-proof covers on mattress

Approximate age of home:
How long have you lived there?
Number of stories:
Basement?
Number of occupants:
Any smokers? Who? Does their smoking affect your symptoms?

PETS:

Type (cat, dog, bird, etc)	Number	How long present:	indoors / outdoors	Any symptoms caused by close contact?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OCCUPATIONAL INFLUENCES: (do any occupational influences / exposures impact your symptoms? Describe:
_____
_____

ACTIVITIES: Describe your hobbies / social / athletic activities:
_____
_____
Do any of these cause an increase in your symptoms?

GEOGRAPHIC HISTORY: Please list localities, where you have lived, how long you lived there, and relation to symptoms

City, State	**Duration**	**Remarks about allergy symptoms:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Father	☐ Alive	☐ Deceased	☐ Unknown	Age/cause of death:
Mother	☐ Alive	☐ Deceased	☐ Unknown	Age/cause of death:
Brothers (#)	☐ Alive	☐ Deceased	☐ Unknown	Age(s) /cause(s) of death:
Sisters (#)	☐ Alive	☐ Deceased	☐ Unknown	Age(s) /cause(s) of death:

Do you have family members (blood relatives) with:	Mother	Father	Brother	Sister	Son	Daughter	Grand-parent
Asthma	☐	☐	☐	☐	☐	☐	☐
COPD / Emphysema	☐	☐	☐	☐	☐	☐	☐
Nasal Allergies	☐	☐	☐	☐	☐	☐	☐
Chronic Sinusitis or Nasal Polyps	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐	☐
Eczema or Atopic Dermatitis	☐	☐	☐	☐	☐	☐	☐
Recurrent Hives / Swelling	☐	☐	☐	☐	☐	☐	☐
Immune Deficiency	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

PAST MEDICAL HISTORY: List other medical problems / issues you have (ie high blood pressure, back pain, etc):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST SURGICAL HISTORY: List any surgery or hospitalizations you have had:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ADDITIONAL REVIEW OF SYSTEMS: (check all that apply)

	Conditions	Details if Yes:		Symptoms	Details if Yes:
☐	Head trauma		☐	Fever	
☐	Heart disease / angina		☐	Severe fatigue	
☐	Irregular heart rate / rhythm		☐	Depression / Anxiety	
☐	Heart murmur		☐	Vision Change	
☐	High blood pressure		☐	Muscle Ache	
☐	High cholesterol		☐	Joint Pain	
☐	Ulcer / Gastritis		☐	Bowel Habit Changes	
☐	Esophageal reflux		☐	Abdominal Pain	
☐	Chronic diarrhea		☐	Vomiting	
☐	Hepatitis		☐	Painful Urination	
☐	Bladder infections		☐	Lymph node swelling	
☐	Kidney / renal disease		☐	Night Sweats	
☐	Arthritis		☐	Easy Bruising / Bleeding	
☐	Other bone / joint problems		☐	Passing out	
☐	Osteoporosis		☐	Heat / Cold intolerance	
☐	Diabetes / blood sugar		☐	Unintentional weight gain/loss	
☐	Thyroid condition		☐	Numbness/ weakness	
☐	Stroke		☐	Other Pain	