Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN
Jennifer Bickford, APRN

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 our practice. See below for required check in times:

- ☐ Dr Jeffrey Nugent - Please check in **15 minutes** prior to your appointment time
- ☐ Dr Maria Reyes - Please check in **30 minutes** prior to your appointment time
- ☐ Shelli Marie Nelson, APRN - Please check in **15 minutes** prior to your appointment time
- ☐ Cynthia Repella, APRN - Please check in **15 minutes** prior to your appointment time
- ☐ Jennifer Bickford, APRN - Please check in **15 minutes** prior to your appointment time

In addition to the enclosed paperwork, you will receive a text and/or email three business days prior to your appointment. In this text/email, there will be a link to complete the required virtual registration. **Please complete both the enclosed paperwork AND virtual registration prior to checking in for your appointment. If one or more component is not complete at the time of check in, we will need to reschedule your appointment.**

Because we are a specialist, we ask that you call your insurance before arriving for your appointment 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 do not hesitate to call if you have any questions. We are looking forward to seeing you!

Sincerely yours,

Northern Nevada Allergy Staff

RENO OFFICE:
8610 Technology Way
Reno, NV 89521

CARSON CITY OFFICE:
3086 Silver Sage Drive
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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	