HILL COUNTRY
Allergy & Asthma

NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Date: _____

Age: _____ Male ❑ Female ❑ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Drivers License #: _____ Employer: _____

Occupation: _____ Work Phone: (_____)_____

Email Address: _____

BILLING CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed in its entirety.)*

Insurance Name: _____ Phone: (_____)_____

Claims Address: _____

City: _____ State: _____ Zip: _____

ID#: _____ Medicare # (*if applicable*): _____

Group/Account #: _____ Group Name: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's Social Sec #: _____

HOW DID YOU HEAR ABOUT US?

❑ Doctor: _____ ❑ Insurance

❑ Friend ❑ Internet /Website

❑ Ad (*which publication?):* _____ ❑ Radio

ACKNOWLEDGEMENTS/CONSENTS *(please initial on the line next to each section after reading)*

Patient Name: _____ Date of Birth: _____ Date: _____

_____ **Receipt of Notice of *Privacy Practices***

I, *(print patient or guardian name)*_____, have read a copy of Hill Country Allergy & Asthma's *Notice of Privacy Practices.* (This document is available at our front desk or HillCountryAllergy.com.)

_____ **Cancellation Policy**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Hill Country Allergy & Asthma reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment within 24 hours.

_____ **Release of Medical Information**

I **do / do not** *(circle one)* authorize Hill Country Allergy & Asthma and its designated representatives to release medical information to my spouse, parent, or guardian.

_____ **Contact Permission**

In the event that Hill Country Allergy & Asthma needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to *(check all that apply)*:

- ❑ Leave a message on an answering machine.
- ❑ Speak with spouse / significant other. (Name:_____)
- ❑ Speak with other family members.

_____ **Consent to Treatment**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated office staff as is deemed necessary in the medical provider's judgement.

_____ **Authorization / Assignment / Financial Responsibility**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Hill Country Allergy & Asthma for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____

Signature of Patient (or guardian) Date

HILL COUNTRY
Allergy & Asthma

NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Date: _____

Referred By: _____ Primary Care Doctor: _____

Here Today With: _____ Other Family Who Are HCAA Patients? _____

MAIN REASON(S) FOR TODAY'S VISIT

What are the main reason(s) for today's visit? _____

When was the first time you had this problem? _____

When did this episode start? _____ How often do episodes recur? _____

What time of day are symptoms worse? *(circle)* morning noon afternoon nighttime all the time anytime

During which months is it most severe? *(circle)* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec all year

Are symptoms worse in certain locations? *(circle)* home work outside indoors other _____

Suspected causes: *(circle)* trees weeds grass mold dust perfumes scents heat cold weather changes smoke stress cats dogs other animals_____ foods_____ other_____

How long have you lived in this area? _____ Moved from where? _____

Where did you grow up? _____

REVIEW OF SYMPTOMS *(Circle any current symptom/description that appliesor "NS" if no symptoms.)*

General healthy fever chills night sweats tired weight loss weight gain

Nose NS congestion decreased sense of smell post nasal drip nasal discharge (runny/thick/clear/discolored) sneezing snorting rubbing bleeds

Sinus NS infections (past/constant/frequent/occasional) pressure drainage

Ears NS infections (past/constant/frequent/occasional) pressure popping discharge rupture earache hearing loss

Eyes NS itchy watery red burning dry swollen eyelids puffy dark circles under eyes

Mouth NS bad breath gum problems lip swelling pain in teeth grinding itching ulcers tongue swelling

Throat NS difficulty swallowing sore clearing snoring hoarseness loss of voice post nasal drip swelling

GI NS heartburn vomiting nausea diarrhea constipation cramping bloating

Chest NS tightness pain palpitations heaviness pressure congestion cramping bloating

Wheezing NS daily frequent occasional rare associated with illness/exercise

Coughing NS constant/frequent/occasional dry deep hacking gasping turning blue productive of mucus

Shortness/Breath NS nighttime with exercise with normal activity at rest

Urinary NS frequency urgency burning pain difficulty urinating

Joints NS swollen painful

Skin NS itching dry rash swelling

Neuro NS dizziness lightheaded sleep disturbance anxiety depressed passing out numbness tremor

Headache NS

Frequency: constant frequent occasional rare

Severity: incapacitating severe moderate minor

Nature: throbbing dull stabbing

Location: L/R sided top/back of head between/behind eyes temples forehead

Symptoms: sound sensitivity light sensitivity nausea vomiting visual changes pain in teeth

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MEDICATION/MEDICAL HISTORY

1. Current Medications *(prescription, non-prescription, herbal, creams, sprays, pills, liquids, drops):*

   1._____ 4._____ 7._____

   2._____ 5._____ 8._____

   3._____ 6._____ 9._____

2. Have you ever been prescribed an **EpiPen** (adrenalin/epinephrine)? Y N If yes, for:_____
3. What medications have been HELPFUL now or in the past? _____
4. What medications have been UNHELPFUL? _____
5. Drug Allergy/Intolerance: D*escribe when/what reaction occurred or (circle) None Known:*

   1._____ _____

   2._____ _____

   3._____ _____

6. Your preferred pharmacy and location? _____
7. Hospitalizations / Operations (include dates):

   1._____ 4. _____

   2. _____ 5. _____

   3. _____ 6. _____

8. Other problems? *(please circle any that you have now or have had in the past)*

High blood pressure	Reflux	Thyroid problems	Heart attack
Hiatal hernia	Kidney problems	Stroke	Diabetes
Chronic infections	Glaucoma	Emphysema	Skin problems
Cataracts	History of asthma	Lupus/other Autoimmune	Depression
Gout	Liver problems	Bipolar	Arthritis
Cancer of _____	ADD/ADHD	Fibromyalgia	Bleeding problems
Osteoporosis/osteopenia	Other _____		

ENVIRONMENTAL HISTORY

1. Occupation / grade in school / daycare _____
2. Hobbies _____
3. IF CHILD: full term premature *(how early?)*_____ birth weight_____ delivery: vaginal Caesarean adopted

   Complications: before during after birth?_____

   Who has legal custody?_____ With whom does child live?_____

Patient Name: _____ Date of Birth: _____ Date: _____

4. Vaccinations current? Y N **Flu vaccine this year? Y N**
5. Personal tobacco use: never yes, onset_____ how many years?_____ packs per day?_____
6. Alcohol use: never yes, how often: weekly, monthly # of drinks per day_____ # of times >5 drinks per day_____
7. Recreational drug use: never past current_____
8. Any increased HIV risk factors? no not sure yes_____
9. Pets (type/number)_____ how long?_____ inside outside both in bedroom
   Do you have increased allergy symptoms around animals? no yes_____
10. Home: Age of building_____ water damage/leaks visible mold/musty odor
    Please circle appropriate responses below:
    Flooring: carpet tile hardwood throw rugs other_____
    Bedroom: box spring/mattress waterbed stuffed chair/couch throw pillows down pillows and/or comforter tapestries
    Window coverings: cloth roll shades shutters wood/metal/plastic blinds
    Fans: not used yes, in rooms
    Air conditioning: central window units
11. Workplace/school: mold animals chemical exposure paint fumes smoke other_____

ALLERGY HISTORY

1. Have you ever been tested for allergies? Y N Date of last skin test?_____
2. How was testing performed? skin blood (rast)
3. How long ago was the test? Less than 1 year 1-3 years 4+ years don't remember
4. Where can we obtain your allergy test results? _____
5. What were you allergic to? *(all that apply)* trees weeds grasses mold dust mites cats dogs foods insects latex other_____
6. Did you get allergy shots? Y N If yes, how long did you take the shots? _____ years/months/weeks
   If yes, were the shots helpful? Y N
7. Food allergy/intolerance: D*escribe when/what reaction occurred or (circle) None Known:*
   1._____ _____
   2._____ _____
   3._____ _____
8. Insect reactions? Y N If yes, describe insect type and nature/location of reaction _____
9. Latex allergy? Y N If yes, describe type and nature/location of reaction _____

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ASTHMA HISTORY

1. Have you been previously diagnosed with asthma? Yes No (***if "no", please skip to question 11 in this section)***
2. What was your age when your asthma began?_____ months/years
3. During a typical week, how often do asthma attacks awaken you at night?

   less than once/week once or twice/week 3x or more/week more than once/night never
4. During a typical week (in the past 12 months) how often did you use a Beta Agonist inhaler (like Proventil, Albuterol or Ventolin) for asthma? less than once/week once or twice/week 3x or more/week daily more than once daily never
5. During a typical week, how often were your activities limited by asthma symptoms such as cough, wheezing, or shortness of breath? Less than once/week once/week 2x or more/week daily never
6. During the past 12 months, how many times have you gone to the emergency room or had an urgent doctor's visit because of asthma? None 1x 2x 3x or more
7. Have you been admitted overnight to a hospital for asthma or breathing disorder in the last 12 months? Y N
8. Do you get chest tightness, wheezing, or shortness of breath within the first 15 minutes of exercise? Y N
9. Do you check peak flows? N Y, best peak flow value_____
10. Do you have a written Asthma Action Plan? Y N
11. Did you ever have recurrent bronchitis, croup, asthma, reactive airway disease during childhood? Y N
12. Have you had sudden severe episodes of coughing, wheezing, or shortness of breath? Y N
13. Have you colds that "go to the chest" and take more than 10 days to get over? Y N
14. Have you had coughing, wheezing, or shortness of breath in certain places when exposed to animals, tobacco, smoke, perfumes, etc.? Y N
15. Have you used medicine to help breathing? N Y, if yes, do symptoms get better with medicine? Y N
16. Do you get coughing, wheezing, or shortness of breath….. at night? Y N in the morning? Y N with exercise? Y N

SINUS HISTORY

1. Do you have sinus problems? Y N ***(If "no", please skip to next section.)***
2. How many times have you been treated for a sinus infection with an antibiotic in the past year? none 1x 2x 3x or more

   Which antibiotic helped the most?_____
3. What is the color of your nasal drainage? *(mark all that apply)* clear brown white green yellow blood-tinged
4. Have you ever had nasal polyps? Y N
5. Have you ever had an x-ray or CT scan of your sinuses? Y N If yes, when?_____ Where performed?_____
6. Have you ever had sinus surgery? Y N If yes, when?_____

   If yes, what type? Caldwell luc ethmoidectomy graft rhinoplasty septoplasty turbinectomy other_____

   Who was the surgeon?_____ Did the surgery help? Y N somewhat
7. Do the sinus problems disturb your sleep enough to cause fatigue, tiredness or sleepiness during the day? Y N