GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

Welcome to our practice!
We look forward to seeing you!

You are receiving this medical form packet because you have a New Patient Appointment scheduled at Greater Austin Allergy, Asthma & Immunology. Please bring all completed paperwork to your appointment.

A few things to remember before your appointment:

1. **Please be sure to bring a valid form of photo ID and all current insurance cards to your appointment. If you do not present current insurance cards on the day of your visit, we will be unable to file to your insurance.**
2. **Please call at least 24 hours before your appointment to cancel or reschedule; otherwise, you will be billed for a $100 No-Show fee.**
3. **If you will be tested for Allergies, remember to discontinue your antihistamines 5 days prior to your appointment. *These medications interfere with testing and accurate results.***

Please feel free to reach out with any questions regarding your appointment or visit our website at www.greateraustinallergy.com.

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

How did you hear about us?					
Website	Referral	TV/News Ad	Social Media	Radio	Other
Patient Referral: (Name)			Physician Referral: (Name)		

Patient Information		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Best Phone Number:	Best Email Address:	
Title (Mr./Mrs./Ms.):	Sex/Gender:	Race & Ethnicity:
Marital Status:	Date of Birth:	Social Security Number:

Emergency Contact Information		
Contact First and Last Name:	Contact Phone Number:	Relationship:

Insurance Information	
Policy Holder Name:	Policy Holder Date of Birth:
Insurance Carrier:	Member ID:
Group Number:	Coverage Dates:
Primary Care Physician:	Employer:
Relationship to Patient:	Responsible Party Name and Date of Birth:

Office visit co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage.
My signature below confirms that the information provided above is accurate and complete to the best of my knowledge. I consent to the performance of diagnostic procedures, examinations, and rendering of treatment by the medical provider and designated medical staff as it is deemed necessary in the medical provider's best judgement.

Acknowledgement	
Signature of Patient or Responsible Party:	**Date:**

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

Financial Responsibility Policy

1. I understand that I, _____, am responsible for knowing whether or not I am—or my dependent is—covered under my insurance policy and that I will bring my current policy information to the clinic at the time of my visit. **INITIALS:**_____
2. I understand that Greater Austin Allergy, Asthma & Immunology cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges deemed my responsibility to my account. **INITIALS:**_____
3. I understand that Greater Austin Allergy, Asthma & Immunology will bill my insurance company according to all Federal rules and regulations regarding such activities and provides my insurance company with copies of all appropriate and required information and that Greater Austin Allergy, Asthma & Immunology is not responsible for lost claims. **INITIALS:**_____
4. I understand that Greater Austin Allergy, Asthma & Immunology will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims, but that the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and that I am ultimately responsible for all services provided. **INITIALS:**_____
5. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions and/or preexisting conditions or riders on my policy, I am fully responsible for services incurred. **INITIALS:**_____
6. I understand that if I elect to pay privately at my first visit, due to lack of insurance, lack of coverage, failure to provide my insurance card at the time of service or failure to verify coverage, Greater Austin Allergy, Asthma & Immunology will not retroactively submit claim or change account responsibility. **INITIALS:**_____
7. I understand that it is my responsibility to provide accurate and updated insurance information to Greater Austin Allergy, Asthma & Immunology at every visit if applicable. **INITIALS:**_____
8. I understand it is my responsibility to proactively be involved in obtaining required referrals that may be required to obtain care depending on my insurance policy. **INITIALS:**_____
9. I understand that Greater Austin Allergy is partnered with a collection agency and that any outstanding balances of 90+ days that have not received payment or established a pre-defined payment plan, will be submitted to the prospective collection agency. **INITIALS:**_____
10. By signing this form, I am aware that in the event I am without health insurance I will be deemed a self-pay patient and financially responsible for all billed services. **INITIALS:**_____

Assignment of Benefits

1. I understand and agree that I am responsible and must pay all deductibles, co-payments, and amounts disputed by my insurance carrier for healthcare services rendered by Greater Austin Allergy, Asthma & Immunology to me or my dependent. **INITIALS:**_____
2. I understand and agree that Greater Austin Allergy, Asthma & Immunology may utilize any legal means to collect payment for any healthcare services rendered to me or my dependent. In the event that legal action is taken, in order to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recovery of all attorney and or collection fees and costs. **INITIALS:**_____

No-Show/ Late Fee / Card-On-File Policy

For all appointments, we require a 24 hours' notice in the event of cancellation or rescheduling. If full notice is not provided, we will bill **a $100 no show fee** for medical appointments. Additionally, if you are more than 15 minutes late to your appointment and there is insufficient time to perform the appointment, the appointment may be cancelled or rescheduled and you will be subject to a **$100 fee**.

INITIALS:_____

Our policy is to have an active credit card on file to charge for services, past due balances, and no-show fees. I understand that if I opt-out of having a credit card on file, I agree to pay all balances and deductibles, and understand that any unpaid balances could go to collections. I also understand that having a credit card on file is not a formal payment plan.

INITIALS:_____

Please indicate a maximum amount per month you authorize your card to be ran for, if you do not have an active payment plan established and have a patient balance due: $_____. *(Minimum amount of $50 is required)* **INITIALS:**_____

****Please complete form on next page****

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

Financial Responsibility Policy

By signing below, you acknowledge that you understand and agree to our financial policy and authorize Greater Austin Allergy, Asthma &Immunology to use your credit card information on file for all payments. You also acknowledge you have read and agree to the Assignment of Benefits, Cancellation and Late Arrival terms. You also understand that HIPAA privacy laws prevent Greater Austin Allergy, Asthma &Immunology staff from using the above information for any other purpose.

Acknowledgement	
Printed Name of Patient:	**Patient Date of Birth:**
Printed Name of Responsible Party/Legal Guardian (if not patient):	**Date:**
Signature of Patient, Responsible Party or Legal Guardian:	**Date:**

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND BILLING INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices applies to the privacy practices of professional staff, employees, volunteers, and Medical Staff for Greater Austin Allergy Asthma & Immunology. Under the Health Insurance Portability and Accountability Act ("HIPAA"), entities named above may use and disclose your Protected Health Information ("PHI") to facilitate their own treatment, payment and operational activities relating to your care. This Notice of Privacy Practices serves as the Notice of Privacy Practices for Greater Austin Allergy Asthma & Immunology.

Your Health Information Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Forms are available on our website, http://www.austinallergist.com or by contacting Compliance and Privacy at Compliance@greateraustinallergy.com.

- **A copy of this Notice.** You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Paper copies of this notice may be obtained from any registration or admissions desk. You may obtain an electronic copy of this notice on our web site, http://www.austinallergist.com
- **Request an electronic or paper copy of your medical records, including health and claims information.** You may request an electronic or paper copy of your medical record, including health and claims information, and other health information we have about you. Greater Austin Allergy Asthma & Immunology or records vendor may charge you a reasonable, cost-based fee for copying your information. You must make this request in writing.
- **Ask us to correct your medical record or your health and claims records.** You may ask us to correct your health information or health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You must make your request in writing and you must provide a reason for the request.
- **Ask us to limit what we use or share.** You may ask us not to use or share certain health information for treatment, payment, or our operations. If you personally pay in full for an item or service, or someone other than your health plan pays in full for the item or service on your behalf, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" if you have already paid in full for the item or service unless a law requires us to share that information. Otherwise, we are not required to agree to your request, and we may say "no" if it would affect your care.
- **Request confidential communications.** You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Greater Austin Allergy Asthma & Immunology will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not. You must make this request in writing and you must tell us how or where you wish to be contacted.
- **Get a list of those with whom we've shared information.** You may ask for a list (accounting) of the times we've shared your health information, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, or health care operations, or certain other disclosures (such as any you asked us to make). We will include each disclosure we made for the past six (6) years, unless you request a shorter time period. We will provide one accounting a year for free but will charge you a reasonable, cost-based fee if you ask for another one within 12 months.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you feel your rights are violated.** You may complain if you feel we have violated your rights by contacting Compliance@greateraustinallergy.com. You may also file a complaint with the United States Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. *You will not be penalized or retaliated against in any way for filing a complaint.* We will not require you to waive your right to file a complaint as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; or
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

In these cases we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes, which are kept separate from the rest of your medical record; and
- Marketing purposes.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**. We may use your health information and share it with other professionals who are treating you. We also may share your health information with people outside Greater Austin Allergy Asthma & Immunology who may be involved in your medical care, such as health care providers who will provide follow-up care after hospitalization, physical therapy organizations, medical equipment suppliers, laboratories, or pharmacies (verbal or electronic).
- **Payment**. We may use and share your health information to bill and get payment from your insurance company or a third party. For example, we may need to provide your health plan with information about treatment you received for an ear infection so that your health plan will pay us or reimburse you for the treatment. Also, we may share your health information with your other health care providers to assist those providers in obtaining payment from your insurance company or a third party. Greater Austin Allergy Asthma & Immunology may use and share your health information as they pay for your services.
- **Run our organization**. We may use and share your health information to run our organization, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services or improve our services. We can also share your health information in a limited data set, which excludes some identifying information.
- **Business Associates**. We may share your health information with our business associates for any of the purposes listed above.
- **Electronic**. We may share your information electronically.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**. We may share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting births and deaths; reporting suspected abuse, neglect, or domestic violence; reporting reactions to medications or product problems; or preventing or reducing a serious threat to anyone's health or safety. We may share portions of your health information with local, state, and/or federal registry programs as required. We may share your health information for these activities in a limited data set, which excludes some identifying information.
- **Do research**. We may use or share your information for health research. We may share your health information for these activities in a limited data set, which excludes some identifying information.
- **Artificial Intelligence**. We may use AI technologies to assist in documenting care, analyzing health data, supporting clinical decisions and other healthcare operations. These tools do not replace your provider's judgment. In some cases, identified data may be shared with AI vendors or researchers to improve healthcare services.
- **Comply with the law**. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to ensure we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**. We may share health information about you with organ procurement organizations.
- **Work with a medical Examiner or funeral director**. We may share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**. We may use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official or correctional institution; with health oversight agencies for activities authorized by law; or for special government functions, such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions**. We may share health information about you in response to a court or administrative order, or in response to a subpoena.
- **Schools (including Child-Care Facilities, Early Childhood Programs, Primary and Secondary Schools)**. We may share your immunization records with a school with a verbal authorization sometimes.

Greater Austin Allergy Asthma & Immunology Responsibilities

We are required by law to maintain the privacy and security of your oral, written, and electronic PHI. Greater Austin Allergy Asthma & Immunology maintains policies and procedures intended to protect PHI maintained by Greater Austin Allergy Asthma & Immunology in any form. Workforce members with access to your PHI receive privacy training which covers how PHI can be used and disclosed and actions they must take to safeguard your information. Our computer systems protect your electronic PHI at all times. We will let you know promptly if an incident occurs that may have compromised the privacy or security of your information. We will not sell your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind by contacting Compliance@greateraustinallergy.com.

Changes to This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website at http://www.austinallergist.com. This notice is effective January 1, 2026.

Contact

If you have any questions about this Notice or your privacy rights or wish to obtain a form to exercise your rights as described above, you may contact Compliance@greateraustinallergy.com.

Acknowledgement	
Signature of Patient or Responsible Party:	**Date:**

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

Consent to Release of Medical Information

I, (print patient full name) _____, have read a copy of Greater Austin Allergy, Asthma & Immunology's *Notice of Patients' Privacy Rights*. (This document is available at the front desk or online at www.greateraustinallergy.com).

I hereby authorize my personal medical information to be released to the following individuals listed below:

First Name	Last Name	Relationship to Patient	Check One:	
			☐ Medical	☐ Financial
			☐ Medical	☐ Financial
			☐ Medical	☐ Financial

May we have your consent to leave voicemails referencing your personal medical information for the individuals listed above?

☐ Yes, I consent to having my personal medical information left via voicemail for the individual contacts listed above.
☐ No, I do not consent to having my personal medical information left via voicemail for the individual contacts listed above.

If you would like us to leave a voicemail for the contacts listed above, please provide their phone number in the space below:

First Name	Last Name	Phone Number

I, (print patient full name) _____, have read and understand the above information and agree to the terms stated above.

Acknowledgement	
Signature of Patient or Responsible Party:	**Date:**
Signature of Clinical Staff Member:	**Date:**

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

Patient Authorization for Email and SMS Text Communication

Greater Austin Allergy, Asthma & Immunology will use email and SMS text messages for appointment related notices, general notification purposes, account statements, experience surveys, and emergency purposes only. Message frequency will vary. The patient can directly update their communication preferences at any time by logging into their patient portal.

Email communications from Greater Austin Allergy, Asthma & Immunology are on an encrypted server. Greater Austin Allergy, Asthma & Immunology is not responsible for emails reaching any unintended recipients.

I acknowledge that I will inform Greater Austin Allergy, Asthma & Immunology of any changes of email address(es) or phone number(s).

I understand that message and data rates may apply for calls and/or SMS texts by my wireless carrier, and that I'm able to reply HELP or STOP to opt out.

My signature below acknowledges that I have read Greater Austin Allergy, Asthma & Immunology's Authorization for Email and SMS text communication and accept the business Privacy Policy and Terms and Conditions, in addition to consenting to receiving such communication as outlined below.

Place check marks to indicate your communication preferences.	Text	Email
I consent to receive appointment related reminders and confirmations.		
I consent to receive patient campaign and marketing information. *Consent is not a condition of purchase.*		
I consent to receive appointment related reminders and confirmations.		
I consent to receiving patient experience surveys.		
I consent to receiving statement notifications.		
I consent to receive telehealth notifications.		

Acknowledgement	
Patient First and Last Name	**Date of Birth:**
Signature of Patient or Responsible Party:	**Date:**

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

AI-Assisted Documentation Consent Form

At Greater Austin Allergy Asthma & Immunology, we are committed to providing high-quality medical care while incorporating advanced technology to enhance efficiency and accuracy. As part of your care, our providers may utilize Artificial Intelligence (AI) technology to assist in documenting your medical visit. This AI-assisted documentation helps streamline the recording of clinical notes and ensures comprehensive and precise medical records, while allowing your provider to focus on you during your visit.

Understanding AI-Assisted Documentation

- The AI technology used in your appointment assists with transcribing and summarizing discussions between you and your medical provider.
- The AI tool **does not** make clinical decisions or replace the expertise of your provider.
- The AI feature is part of the electronic health record tool your provider uses to document your medical history for your medical record.
- The AI tool does not share your information with any 3rd parties and all information is kept confidential and encrypted.
- Your provider will review, edit, and finalize all AI-generated documentation to ensure accuracy and completeness.
- All AI-assisted documentation is handled in compliance with HIPAA regulations and Greater Austin Allergy Asthma & Immunology data security policies to safeguard your privacy.

Your Consent and Rights

- Participation in AI-assisted documentation is **voluntary**. You have the right to decline its use without any impact on the quality of your care.
- You may request to review the notes documented with AI assistance.
- You may withdraw your consent at any time by informing your provider or clinic staff.
- You have the right to have any questions or concerns regarding AI-assisted documentation answered by your medical provider.

Acknowledgement and Consent

By signing below, you acknowledge that you have read and understand the information provided about AI-assisted documentation. You consent to its use during your medical visit(s) at Greater Austin Allergy Asthma & Immunology and you acknowledge that you have had the opportunity to ask questions and receive answers regarding the use of AI-assisted documentation.

Acknowledgement	
Patient First and Last Name:	**Date of Birth:**
Signature of Patient or Responsible Party:	**Date:**

GREATER AUSTIN ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY
Office: 512-732-2774 | Fax: 512-329-6871
www.greateraustinallergy.com

PATIENT, FAMILY, AND VISITOR CODE OF CONDUCT AND RECORDING POLICY

At Greater Austin Allergy, Asthma & Immunology, we strive to create a welcoming and respectful environment where our medical teams can deliver high-quality healthcare to you and your family. We encourage you to participate actively in your care. Together, by working with you in a safe, respectful, and honest way, we can provide the best possible care.
This policy consolidates our **Code of Conduct** and our **Privacy and Recording Policy** into a single document. By signing the acknowledgment at the end, you confirm that you have received, read, and agree to abide by both policies during your time at our facility.

PART I — CODE OF CONDUCT

To ensure a safe and respectful working environment, Greater Austin Allergy finds certain behaviors to be unacceptable. These behaviors could lead to removal from the building and/or dismissal from the clinic.

UNACCEPTABLE BEHAVIORS

The following behaviors are not permitted at any Greater Austin Allergy facility:

- Aggression
- Abusive language (cursing, shouting, or language of a sexual nature)
- Disrupting another patient's care or experience
- Bullying, intimidating, or harassing staff or other patients
- Engaging in profanity, assault, or the infliction of bodily harm to self or others
- Engaging in or threatening violent behaviors, either in person or in communications
- Making vulgar or derogatory remarks associated with race, ethnicity, sexual orientation, culture, language, age, disability, veteran status, or immigration status
- Damaging property or equipment
- Possessing illegal weapon(s) in prohibited areas
- Making requests that would constitute unethical or illegal behavior on the part of Greater Austin Allergy

ZERO-TOLERANCE STATEMENT

Greater Austin Allergy, Asthma & Immunology maintains a zero-tolerance policy for aggressive behavior directed toward our providers, learners, and staff. If you personally experience or notice any alarming or unsafe behaviors, please report them to a member of our staff immediately.

PART II —PRIVACY AND RECORDING POLICY

We are committed to providing the highest quality healthcare while protecting the privacy, confidentiality, and safety of our patients, visitors, and staff. In compliance with federal privacy regulations, including HIPAA, and to maintain a secure environment, we enforce a strict policy regarding the use of recording devices within our facility.

PROHIBITION OF UNAUTHORIZED RECORDING

The use of cell phones, smart glasses, wearable cameras, or any other personal electronic devices to capture photographs, video footage, or audio recordings is strictly prohibited in all clinical and non-public areas of this facility. This includes, but is not limited to, waiting rooms, exam rooms, treatment areas, hallways, and check-in/check-out desks.

REQUIREMENT OF MULTI-PARTY CONSENT

Patients and visitors may not record conversations, consultations, or medical treatments involving our physicians, nurses, or staff members without the express, real-time verbal or written consent of every individual who will be captured in the frame or audio

recording.

CONDITIONAL EXCEPTIONS

We recognize that recording certain medical instructions can be a helpful tool for patient care. If you wish to record a specific portion of your consultation (such as instructions or complex care steps), you must request permission from your healthcare provider before activating any device. Staff members reserve the right to deny or withdraw this consent at any time during the visit.

ENFORCEMENT AND CONSEQUENCES

As a private medical practice, Greater Austin Allergy, Asthma & Immunology reserves the right to control access to its property. Failure to comply with either the Code of Conduct or the Privacy and Recording Policy constitute a breach of clinic policy. Violations may result in any of the following:

- An immediate request to cease the prohibited behavior and, where applicable, to delete any captured media.
- The immediate termination of the current non-emergent appointment.
- Discharge from the practice and termination of the physician-patient relationship.
- Removal from the premises by law enforcement for criminal trespass if a non-compliant individual refuses to leave when instructed.

PATIENT ACKNOWLEDGMENT AND SIGNATURE

By signing below, I acknowledge that I have received, read, and understand the Greater Austin Allergy, Asthma & Immunology Code of Conduct and Patient and Visitor Privacy and Recording Policy. I agree to abide by these terms during my time at the facility.

Patient Name (Printed)	
Patient or Guardian Signature	
Date	

BRIEFLY DESCRIBE THE REASON FOR THIS VISIT (what is your main concern or symptom?):

_____

CHECK SYMPTOMS YOU HAVE OR HAVE HAD:

Nasal Symptoms ☐ Past ☐ Present

- ☐ Nasal congestion
- ☐ Runny nose
- ☐ Nasal discharge
- ☐ Postnasal drip
- ☐ Snoring
- ☐ Nasal itching
- ☐ Frequent sneezing
- ☐ Frequent nose bleeds
- ☐ Nasal polyps
- ☐ Loss of sense of smell
- ☐ Loss of sense of taste

Sinus ☐ Past ☐ Present

- ☐ Frequent infections
- ☐ Pressure in sinuses
- ☐ Postnasal drip
- ☐ Nighttime cough
- ☐ Sinus headaches
- ☐ Bad breath

How many times in the last year have you taken an antibiotic for a sinus infection? _____

Is so, when was the last time? _____

Have you ever had a sinus CT (CAT scan) or x-rays? ☐ No ☐ Yes

If yes, when was most recent one?

Have you ever had sinus surgery? ☐ No ☐ Yes. If yes, date: _____

Eye Symptoms ☐ Past ☐ Present

- ☐ Itching
- ☐ Watery eyes
- ☐ Redness or burning
- ☐ Swelling of eyelids

Frequent Ear Infections ☐ Past ☐ Present

Have you had pressure equalization tubes? ☐ No ☐ Yes

If yes, date(s): _____

Ear Symptoms ☐ Past ☐ Present

- ☐ Pain ☐ Itching
- ☐ Pressure ☐ Loss of hearing

Headaches ☐ Past ☐ Present

- ☐ Sinus ☐ Migraine
- ☐ Tension ☐ With menses

Location of headaches

- ☐ Frontal ☐ Back of head
- ☐ Temple area ☐ One-sided

Is your headache

- ☐ Sharp pain ☐ Dull pain
- ☐ Throbbing pain

When you have headaches, do you have nausea or vomiting? ☐ do you have difficulty with vision? ☐ are you bothered by light? ☐ are you bothered by noise? ☐

Frequency of headaches

- ☐ Daily ☐ Weekly
- ☐ Occasionally ☐ Seldom

Effective medicines for headaches (list names): _____

_____

Lung Symptoms ☐ Past ☐ Present

- ☐ Asthma
- ☐ Wheezing
- ☐ Chest “colds” or congestion
- ☐ Chest symptoms with exercise
- ☐ Shortness of breath at rest
- ☐ Shortness of breath at night
- ☐ Sudden attacks of shortness of breath
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Bronchiolitis
- ☐ Croup
- ☐ Cough
- ☐ Coughing up blood

Gastrointestinal ☐ Past ☐ Present

- ☐ Frequent nausea or vomiting
- ☐ Frequent episodes of diarrhea
- ☐ Heartburn
- ☐ Regurgitation of food
- ☐ Acid or sour taste in your mouth in the morning
- ☐ Abdominal cramping
- ☐ Itching of mouth or throat
- ☐ Food allergy: list which foods

_____

_____

_____

Skin Symptoms ☐ Past ☐ Present

- ☐ Hives ☐ Itching
- ☐ Eczema ☐ Contact rash

WHICH OF THE FOLLOWING TRIGGER FACTORS MAKE YOUR SYMPTOMS WORSE? (check all that apply)

- ☐ Bronchitis
- ☐ Colds, influenza
- ☐ Sinus infections
- ☐ Nonsteroidal antiinflammatory medicines (such as ibuprofen or naproxen)
- ☐ Aspirin
- ☐ Exercise
- ☐ Wines, alcoholic beverages
- ☐ Cigarette smoke
- ☐ Perfumes, hairsprays, strong odors
- ☐ Cold air
- ☐ Nighttime
- ☐ Weather changes
- ☐ Cutting grass
- ☐ Cats
- ☐ Dogs
- ☐ Other animals (specify)

_____

- ☐ Foods (specify)

_____

_____

_____

- ☐ Food additives (specify)

_____

_____

_____

- ☐ Laughter
- ☐ Strong emotions or stress
- ☐ Menstrual cycles
- ☐ Damp, musty places
- ☐ House dusting or vacuuming
- ☐ Occupational exposures
- ☐ Air pollution

YOUR NAME _____ **YOUR DATE OF BIRTH** _____

ALLERGY HISTORY

Are your symptoms: ☐ Year-round ☐ Seasonal ☐ Year-round with seasonal increases?
If seasonal, which season(s)? (check all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter
Which months are worse for you? (check all that apply)
☐ January ☐ February ☐ March ☐ April
☐ May ☐ June ☐ July ☐ August
☐ September ☐ October ☐ November ☐ December

Have you had allergy skin testing? ☐ No ☐ Yes If yes, by whom? _____

Please list dates and results of these tests: _____

_____

Have you had allergy shots? ☐ No ☐ Yes

If yes, when did you receive them and for how long? _____

Did allergy shots help your symptoms? ☐ No ☐ Yes

Please list all known inhalant, food, and medicine allergies other than those detected only by skin testing

WHAT YOU ARE ALLERGIC TO	REACTION

Do you have any other allergy problems, such as latex sensitivity or insect sting allergy (bee, wasp, yellow jacket, hornet, or fire ant)?

☐ No ☐ Yes If yes, please describe: _____

_____

_____

USE OF MEDICATIONS

Please list all current ORAL and INHALED medications prescribed by your doctor and any nonprescription medicines you are taking:

MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	TAKEN DAILY?	MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	TAKEN DAILY?
		YES NO			YES NO
		YES NO			YES NO
		YES NO			YES NO
		YES NO			YES NO
		YES NO			YES NO
		YES NO			YES NO
		YES NO			YES NO

Please list medications you have taken in the past but no longer are taking for the symptoms being evaluated here: _____

_____

_____

PAST MEDICAL HISTORY

List all hospitalizations or ☐ **None**

DATES OF HOSPITALIZATION	NAME OF HOSPITAL	REASON FOR HOSPITALIZATION

Please list all surgical procedures and the date they were done or ☐ **None**"

PROCEDURE	DATE

Have you had any serious accidents? ☐ No ☐ Yes If yes, please describe _____
Are your immunizations up to date? ☐ No ☐ Yes
Date of last flu vaccination _____ Date of last pneumonia vaccination _____

ASTHMA SEVERITY

Have you been admitted to hospital because of asthma? ☐ No ☐ Yes. If yes, how many in the last year? _____
Have you been admitted to an Intensive Care Unit because of asthma? ☐ No ☐ Yes. If yes, when? _____
Have your asthma symptoms resulted in respiratory arrest, intubation or use of a mechanical ventilator? ☐ No ☐ Yes

List any previous testing you have had or ☐ **None**

	APPROXIMATE DATE	RESULT
☐ Chest x-ray		
☐ Sinus CT or x-ray		
☐ Sweat chloride test		
☐ Pulmonary function tests		
☐ Barium swallow		
☐ Nasopharyngoscopy or laryngoscopy		
☐ Esophagoscopy		
☐ Bronchoscopy		
☐ Immunoglobulin studies		
☐ Other _____		

Have you had any of the following or ☐ **None**?

☐ Cataracts	☐ Diabetes	☐ Hiatal hernia	☐ Any severe infections
☐ Thyroid disease	☐ Elevated cholesterol	☐ Irritable bowel syndrome	Other medical problems?
☐ Migraine headaches	☐ Pneumonia	☐ Gastroesphageal reflux	_____
☐ Heart disease	☐ Cancer	☐ Positive tuberculin skin test	_____
☐ High blood pressure	☐ Hepatitis	☐ Osteoporosis	_____

Other significant illnesses _____

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you are currently experiencing or have had or ☐ **None**

General	Fever, chills, night sweats, loss of appetite, fatigue, weight loss, weight gain, cold intolerance, heat intolerance, headaches
Eye, Ear, Nose, or Throat	Blurry vision, double vision, eye irritation, eye discharge, vision loss, eye pain, discomfort from bright light, glaucoma
	Ear pain or discharge, ear infections, ringing in ears, decreased hearing, loss of balance
	Excessive tearing, dry eyes, itchy eyes, conjunctivitis, eye discharge
	Nasal congestion, runny nose, nasal discharge, postnasal drainage, nasal itching, frequent sneezing, nosebleeds, loss of sense of smell, loss of sense of taste,
	Sinus infections, pressure in sinuses, badbreath
	Sore throat, hoarseness, trouble swallowing liquids or food
Lymph Nodes (Lymph "Glands")	Swelling, tenderness
Heart	Chest pains, palpitations, fainting, shortness of breath on exertion, inability to lie flat in bed, swelling of hands or ankles
Lungs	Wheezing, chest congestion, chest symptoms with exercise, shortness of breath at rest, breathing problems that wake you from sleep, pneumonia, bronchitis, croup, cough, coughing up blood
Intestinal Tract	Nausea, vomiting, diarrhea, constipation, change in bowel habits, indigestion, abdominal pain, food intolerances, blood in stool
Reproductive	Irregular periods, skipped periods, unusual vaginal bleeding, genital sores, menopause, infertility, miscarriages, impotence or decreased libido, unplanned pregnancy, planned pregnancy
Urinary	Pain when urinating, blood in urine, discharge, frequent urination, trouble starting to urinate, awakening at night to urinate, incontinence, kidney stones, kidney infections, prostate problems
Rheumatologic & Orthopedic	Back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis, gout, osteoporosis, fractured bones
Skin	Skin rash, skin tumors or growths, excessive hair loss, severe itching, dryness, abnormal bruising, bleeding
Neurologic & Psychologic	Transient paralysis, numbness, weakness, tingling sensations, seizures, fainting spells, tremors, dizziness, difficulty with memory, inability to concentrate, migraine headaches, anxiety, depression

Please elaborate on any symptoms that are particularly bothersome to you:_____

_____

_____

FAMILY HISTORY

FOR ADULT: Age and gender of your children or ☐ **None**: _____

FOR CHILD: Age and gender of child's siblings or ☐ **None**: _____

☐ **None or unknown**	Father	Mother	Patient's siblings	Grand-parents	Patient's children	Others
Seasonal nasal symptoms (hayfever)	☐	☐	☐	☐	☐	☐
Chronic nasal symptoms	☐	☐	☐	☐	☐	☐
Sinusitis	☐	☐	☐	☐	☐	☐
Recurrent wheezing	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bronchitis (non-smoker)	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐	☐
Medicine allergy	☐	☐	☐	☐	☐	☐
Recurrent infections	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐

Do you have any relatives

With cystic fibrosis? ☐ No ☐ Yes If yes, who? _____
Who have had nasal polyps or sinus surgery? ☐ No ☐ Yes If yes, who? _____
Who have had allergic reactions to aspirin or ibuprofen? ☐ No ☐ Yes If yes, who? _____
Who have had children who died in the first 5 years of life? ☐ No ☐ Yes If yes, who? _____
Who have received gammaglobulin shots for frequent infections? ☐ No ☐ Yes If yes, who? _____

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Past ☐ Present If past or present, when did you started smoking? _____ quit smoking? _____
How many packs per day do you (did you) average? _____

ENVIRONMENTAL HISTORY

How long have you lived in your current hometown? _____ How long have you lived In your present home? _____
How old is the dwelling in which you live? _____ Do you live in a house, apartment, or trailer? _____
Check rooms with wall-to-wall carpeting: ☐ bedroom ☐ living room ☐ TV room ☐ other _____
What kind of bed do you sleep on? ☐ single bed ☐ bunk bed ☐ waterbed ☐ other _____
For child, stuffed animals in bedroom ☐ Yes ☐ No If yes, in bed? ☐ Yes ☐ No
Do you have an allergen-proof cover on your mattress? ☐ Yes ☐ No
Type of pillow or comforter (check all that apply) ☐ foam ☐ feather ☐ fiberfill ☐ other _____
Do you have an allergen-proof cover on your pillow? ☐ Yes ☐ No
How often is the inside of the pillow washed? ☐ once a month or more ☐ less often than once a month
What temperature water do you use to wash bedding (blankets and sheets) ☐ cold or warm ☐ hot
Do you have any warm-blooded pets? ☐ No ☐ Yes If yes, check all that apply and give number that you have:
☐ cat (how many?_____) ☐ dog (how many?_____) ☐ bird (how many?_____) ☐ other _____
Do any pets stay or come indoors? ☐ No ☐ Yes If yes, where do the pets sleep? _____
Does anyone smoke in your home? ☐ No ☐ Yes

FOR ADULT

Your occupation_____Your employer _____
How long in this occupation? _____
Spouse's occupation_____Spouse's employer _____
How long in this occupation? _____

Do you believe that your current or previous occupation has any bearing on your illness? ☐ No ☐ Yes
If yes, please explain: _____

_____

Have you had any job with high exposure to fumes, chemicals, dust or other noxious substances? ☐ No ☐ Yes
If yes, please explain: _____

_____

FOR CHILD

Father's occupation _____ Father's employer _____
How long in this occupation? _____
Mother's occupation _____ Mother's employer _____
How long in this occupation? _____

For child, is or was he or she ever in day care? ☐ No ☐ Past ☐ Present
If Past or Present, at what age did he or she start? _____ Number and ages of children there? _____
If Past or Present, how often did or does he or she attend daycare? _____
Is or was the child ever in pre-school? ☐ No ☐ Past ☐ Present
If Past or Present, at what age did he or she start? _____ Number and ages of children there? _____
If Past or Present, how often did or does he or she attend preschool? _____
If in school, current grade: _____
Are there other children in the home besides siblings? ☐ Yes ☐ No If yes, give number and ages _____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT?

_____

_____

WHO IS YOUR PRIMARY CARE DOCTOR?

Name _____ Specialty._____

WHICH DOCTOR REFERRED YOU HERE?

Name _____ Specialty. _____

ARE THERE OTHER DOCTORS WHO HAVE SEEN YOU OR ARE SEEING YOU?

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty

Name _____ Specialty

Name _____ Specialty

IF ANY OTHER FAMILY MEMBERS ARE PATIENTS OF THIS PRACTICE, PLEASE LIST THEIR NAMES:

_____ _____

_____ _____

Thank you very much for completing this questionnaire.

REVIEWED BY YOUR DOCTOR :_____

SIGNATURE DATE