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.

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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:**

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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****

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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:**

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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:**

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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:**

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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 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:**

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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:**

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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	

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New Patient Assessment Questionnaire

Patient Name:	Date of Birth:
Referring Provider (if applicable) and other providers seen on a regular basis:	
Reason for visit:	

Nasal Symptoms

Have you had any nasal symptoms? If so, what symptoms did you have?

Are these symptoms:

Year-round?	Yes	No	Unsure	
Seasonal?	Yes	No	Unsure	If yes, which season(s)?
Do symptoms improve with travel (outside of the state of Texas)?	Yes	No	Unsure	
Do symptoms worsen around pets?	Yes	No	Unsure	If yes, which pets?

Which medications have you tried to relieve your symptoms and did they help?

Eye Symptoms

Have you had any eye symptoms? If so, what symptoms did you have?

Are these symptoms:

Year-round?	Yes	No	Unsure	
Seasonal?	Yes	No	Unsure	If yes, which season(s)?

Which medications have you tried, and did they help?

Ear Symptoms

Have you had any ear symptoms? If so, what symptoms did you have?

Respiratory Symptoms

Do you have any breathing or chest symptoms? If so, what symptoms?				
Have you ever been diagnosed with Asthma?	Yes	No	Unsure	If yes, when were you diagnosed?
Are these symptoms:				
Year-round?	Yes	No	Unsure	
Seasonal?	Yes	No	Unsure	If yes, which seasons?
Do your symptoms worsen with exercise?	Yes	No	Unsure	
Do your symptoms get worse in the cold?	Yes	No	Unsure	
Do your symptoms get worse with infections?	Yes	No	Unsure	
Have you ever been hospitalized or visited an ER for your breathing symptoms?	Yes	No	Unsure	If yes, when:
How often do you have breathing symptoms?				
Have you tried any medications for your breathing symptoms? If so, which ones and did they help?				

Skin Symptoms

Have you had any rashes? If so, please describe them.

Immunodeficiency/Recurrent Infections

Have you ever been diagnosed with an immunodeficiency?	Yes	No	Unsure	If yes, when were you diagnosed? Describe your diagnosis:
Do you have a history of recurrent infections? Ex: pneumonia; sinus; skin, fungal or atypical viral infections; abscesses, etc.? If so, please describe.				

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Food, Medication, and Insect Allergies

Do you have any allergies or adverse reactions to foods? If so, what foods and what happened?
Do you have any allergies or adverse reactions to medications? If so, what medications and what happened?
Do you have any allergies or unusual reactions to stinging insects (bee, wasp, fire ant, etc.)? If so, which one and what happened?

Medical, Surgical & Family History

Please select any/all medical conditions you have been diagnosed with below:

Eye Conditions					
Cataracts	Glaucoma	Other:			
Endocrine					
Diabetes, Type I	Diabetes, Type II	Hashimoto's Thyroiditis	Hypothyroidism	Hyperthyroidism	Addison's Disease
Other:					
Ear, Nose and Throat					
Hearing Loss	Deviated Septum	Other:			
Cardiovascular (Heart)					
High Blood Pressure	High Cholesterol	History of a Stroke	Coronary Artery Disease	History of Arrhythmia	Peripheral Vascular Disease
Other:					
Respiratory (Lungs)					
COPD	Asthma	History of Pneumonia	History of TB/positive PPD		
Other					
Liver and Kidney					
Liver Disease	Abnormal Liver Tests	Hepatitis	Kidney Disease	Other:	
Other:					

Have you ever been hospitalized or had any surgeries? If so, please list them below:

Please select any family members who have the following illnesses:						
Allergies	Mother	Father	Sister(s)	Brother(s)	Children	Other
Asthma	Mother	Father	Sister(s)	Brother(s)	Children	Other
Eczema or other rashes	Mother	Father	Sister(s)	Brother(s)	Children	Other
Swelling (Angioedema)	Mother	Father	Sister(s)	Brother(s)	Children	Other
Immune Deficiency	Mother	Father	Sister(s)	Brother(s)	Children	Other
Autoimmune Disease	Mother	Father	Sister(s)	Brother(s)	Children	Other

Environmental History

What is your job?

What are your current living arrangements, hold old is the structure, and how long have you lived there?

House	Condo	Duplex	Apartment	Dorm	Trailer

Is there carpeting in your bedroom?	Yes	No		
Do you have air filters in your home?	Yes	No		
Are there dust mite covers on your mattress and/or pillows?	Yes	No		
Is there anything feathered on your bed (pillow, blanket)?	Yes	No		
Is there any tobacco exposure in your home?	Yes	No		
Are there any dogs in your home?	Yes	No	If yes, how many?	
Are there any cats in your home?	Yes	No	If yes, how many?	
Are there any birds in your home?	Yes	No	If yes, how many?	
Are there any mice, guinea pigs, rats, rabbits or any other furred mammals in your home?			Yes	No
Do you have any mold issues in your home?			Yes	No
Are there any workplace exposures, hobbies or recreational activities that worsen your symptoms?			Yes	No

If yes, please specify below:

How long have you lived in the Austin area, where did you live before Austin, and when did you live there?

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Smoking & Tobacco Use		
Smoking status:		
Have you ever smoked tobacco or other substances?	Yes	No
Are you still smoking?	Yes	No – When did you quit?
If you are a current smoker, how much are you smoking per day and for how long? Ex: number cigarettes per day, number cigars per day, etc.:		

Previous Diagnostics and Studies			
Have you had any of the following imaging studies?			
Chest X-ray, CT, MRI	Yes	No	When/Results:
Sinus CT	Yes	No	When/Results:
Other:			

Have you ever had skin testing? If so, when and what were the results?
Have you ever used immunotherapy/allergy shots/allergy drops? If so, when and did it help?

Current Medications:
Please list your current medications (prescribed and over-the-counter), vitamins, and supplements. When was each started?

Pharmacy Information		
Preferred Pharmacy Name:	Phone:	Address or Intersection: