West Houston ENT & Sleep Center, PA
12606 West Houston Center Blvd #220, Houston Tx 77082; Tel: 281.556.1102; Fax: 281.556.1340

REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Email_____
Patient Last Name_____ First Name_____ Initial_____
Street Address_____
City_____ State_____ Zip_____
Sex M F Age_____ Birth date_____ Single Married Widowed Separated Divorced

Social Security #_____ Driver's License #_____

Insured Name_____ How and where did you learn about this clinic?_____
Last Name First Name Initial
Relationship To Insured Self Spouse Child Other
Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ Full-time Part-time City State Zip Years Employed
SPOUSE (PARENT)	Name_____ Birthdate_____ SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ _____ Address_____ Phone_____ Occupation_____ City State Zip Full-time Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: ID #:
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: ID #:
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? Yes No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant Yes No Pacemaker Yes No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u>, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA</u>. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

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Notice of Privacy Practices

Dr. James J. Ludwick

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a paper copy of this at any time even if we communicate with you electronically.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, we provide specialty care and may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he/she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may

disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Workers' Compensation
We may disclose your medical information as required by workers' compensation law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. restrict the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to Dr. James Ludwick, 12606 West Houston Center Blvd #220 Houston Texas 77082.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing.
Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to our office. We will respond within 60 days of your request.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact me or you may send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Payment Policy

***** Please note: ALL PAYMENT IS DUE AT THE TIME OF SERVICE *****

In order for Dr. James Ludwick to adequately evaluate and diagnose your complaint/illness you may require an in-office procedure. Common diagnostic procedures include:

- Nasal Endoscopy/Nasopharyngoscopy
- Flexible Laryngoscopy
- Removal of impacted cerumen to allow visualization of the ear drum
- Use of microscope

In addition, common in-office therapeutic procedures include:

- Inferior turbinate reduction
- removal of nasal or ear foreign bodies
- cerumen removal
- Pillar Procedure
- biopsies
- nasal debridement

You may be responsible for the charges associated with these procedures which typically range from $50 - $250 ($90 - $1500 for therapeutic procedures). This will depend on your specific health care benefits from your insurance provider. As a courtesy, at the time of your visit we will do our best to notify you of any co-insurance or deductibles which apply to your policy, *but it is ultimately your responsibility to know what your health care policy covers*.

These payments are expected at the time of service unless prior written arrangements have been made with our office. If, upon receiving your explanation of benefits (EOB) from your insurance carrier, an overpayment was made on your part, a refund will be mailed to the address on file with our office.

Please feel free to ask the receptionist if you have any questions regarding this policy so we can minimize any confusion concerning our charges.

Thank you,

West Houston ENT & Sleep Center
Billing and Insurance Dept.

I acknowledge that I may be responsible for payment due at the time of service other than my office visit co-pay or deductable due to my benefit plan.

X_____ **X**_____

Patient/Guardian Signature **Date**

X_____

Patient name

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New Allergy Patient Health History

IN YOUR OWN WORDS, WHAT BRINGS YOU TO SEE US TODAY?_____

PLEASE TELL US YOUR: HEIGHT_____ **WEIGHT**_____**lbs**

PAST HEALTH HISTORY: Has your doctor ever told you that you have any of the following (These are **NOT** symptoms)?

Face:
- Skin Cancer ❑No ❑Yes When?_____
  - Type ❑Basal Cell ❑Squamous Cell ❑Melanoma
- Bell's Palsy/Facial weakness ❑No ❑Yes When?_____

Ears:
- Recurrent Infections ❑No ❑Yes When?_____
- Hearing Loss ❑No ❑Yes When?_____
- Ear Fluid ❑No ❑Yes When?_____
- Cholesteatoma ❑No ❑Yes When?_____

Nose & Sinus:
- Nasal Allergies ❑No ❑Yes When?_____
- Sinusitis ❑No ❑Yes When?_____
- Nasal Polyps ❑No ❑Yes When?_____
- Nose Bleeds ❑No ❑Yes When?_____

Cardiovascular:
- Arrhythmia ❑No ❑Yes When?_____
- Heart Valve Disease ❑No ❑Yes When?_____
- High Blood Pressure ❑No ❑Yes When?_____
- High Cholesterol ❑No ❑Yes When?_____
- Heart Attack ❑No ❑Yes When?_____

Pulmonary:
- Asthma ❑No ❑Yes When?_____
- Emphysema/COPD ❑No ❑Yes When?_____
- Sleep Apnea ❑No ❑Yes When?_____
- Tuberculosis ❑No ❑Yes When?_____
- Use oxygen at home ❑No ❑Yes When?_____

Have you ever had:
- Hepatitis ❑No ❑Yes When?_____
- HIV ❑No ❑Yes When?_____
- Mononucleosis ❑No ❑Yes When?_____

Stomach/Digestive:
- Reflux ❑No ❑Yes When?_____
- Liver Disease ❑No ❑Yes When?_____
- Gastric/duodenal Ulcers ❑No ❑Yes When?_____

Kidney:
- Kidney Stones ❑No ❑Yes When?_____
- Renal Failure ❑No ❑Yes When?_____

Endocrine
- High blood calcium ❑No ❑Yes When?_____
- Diabetes ❑No ❑Yes When?_____
- Thyroid Disease ❑No ❑Yes When?_____
  - ❑Hyperthyroidism ❑Hypothyroidism
  - ❑Nodule

Blood/Lymph Nodes:
- Anemia ❑No ❑Yes When?_____
- Bleeding Disorder ❑No ❑Yes When?_____
- Leukemia/Lymphoma ❑No ❑Yes When?_____

Have you ever been diagnosed with cancer?
❑No ❑Yes **Please list location and year diagnosed.**
Location_____Year_____
Location_____Year_____

Neurological/Psychiatric (please check which applies to you)
❑Stroke ❑Parkinson's ❑Alzheimer's ❑Seizures
❑Depression ❑Anxiety Disorder ❑Panic Attacks

Have we missed anything? _____
_____

SURGERIES: (Please include type or location and year of surgery)
❑EAR TUBES ❑TONSILLECTOMY ❑SINUS SURGERY
❑SEPTUM ❑SLEEP SURGERY ❑RHINOPLASTY
OTHER:_____
_____

Have you ever been hospitalized? ❑No ❑Yes

Have you ever had a problem with anesthesia? ❑No ❑Yes
Reaction_____

CURRENT MEDICATIONS:(Includes all prescription, over-the-counter medications, herbal and vitamin supplements)

❑CHECK **HERE** IF YOU DON'T TAKE ANY MEDICATIONS

Name of Medication	Dose	Times/day

Do you take: ❑Aspirin ❑Plavix ❑Coumadin ❑Ginko Biloba ❑Ginseng ❑Echinacea ❑Garlic

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New Allergy Patient Health History

***MEDICATION ALLERGIES*:** ❑CHECK **HERE** IF YOU HAVE NO MEDICATION ALLERGIES

Name of Medication	Type of Reaction (ex: rash, hives, swelling)

SOCIAL HISTORY:

I think my overall health is: ❑Excellent ❑Good ❑Average ❑Fair ❑Poor
Marital Status ❑Married ❑Separated ❑Divorced ❑Widowed ❑Single ❑Significant Other
Children? ❑No ❑Yes Number____
Occupation:_____❑Full Time ❑Part time

Are you a Jehovah Witness? ❑No ❑Yes
Exercise regularly? ❑No ❑Yes **Days/Week**:_____
Have you *ever* used illicit drugs? ❑No ❑Yes
Do you *currently* use them? ❑No ❑Yes
Type: _____

Do you use or have you used tobacco products? ❑No ❑Yes
|| **If yes, year began?** _____
|| ❑Cigarettes Packs/day_____❑Chew Tobacco
|| ❑Cigar/Pipe Number/day_____
|| **Quit?**❑No ❑Yes **Year** _____
|| **Do you drink alcoholic beverages?** ❑No ❑Yes
|| **If yes** ❑Occasionally ❑Daily (**Drinks/day)**_____

How many cups of caffeinated beverages do you drink/day? || ❑1-3 ❑3-5❑5-7 ❑>7

FAMILY HISTORY:

Problems with anesthesia	❑Mother	❑Father	❑Brother	❑Sister
Ears:				
Hearing loss before age 20	❑Mother	❑Father	❑Brother	❑Sister
Hearing loss after age 20	❑Mother	❑Father	❑Brother	❑Sister
Nose & Sinus:				
Nasal Allergies	❑Mother	❑Father	❑Brother	❑Sister
Nose Bleeds	❑Mother	❑Father	❑Brother	❑Sister
Nasal Polyps	❑Mother	❑Father	❑Brother	❑Sister
Cardiovascular				
Heart Attack	❑Mother	❑Father	❑Brother	❑Sister
High Cholesterol/Heart Disease	❑Mother	❑Father	❑Brother	❑Sister
High Blood Pressure	❑Mother	❑Father	❑Brother	❑Sister
Pulmonary:				
Asthma	❑Mother	❑Father	❑Brother	❑Sister
Lung Cancer	❑Mother	❑Father	❑Brother	❑Sister
Gastrointestinal				
Stomach/Esophageal Cancer	❑Mother	❑Father	❑Brother	❑Sister
Reflux	❑Mother	❑Father	❑Brother	❑Sister
Nervous System				
Stroke	❑Mother	❑Father	❑Brother	❑Sister
Brain Tumors	❑Mother	❑Father	❑Brother	❑Sister
Blood & Lymph Nodes				
Bleeding/Clotting Disorder	❑Mother	❑Father	❑Brother	❑Sister
Leukemia/Lymphoma	❑Mother	❑Father	❑Brother	❑Sister

Other:_____

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New Allergy Patient Health History

REVIEW OF SYSTEMS:

General Health Problems
❑Fatigue ❑Fever/Chills ❑Headache ❑Loss of appetite
❑Night Sweats ❑Recent Illness ❑Weight loss

Eye
❑Blurry Vision ❑Bulging of eyes ❑Double Vision
❑Itchy/Watery Eyes

Ear
❑Ear Pain ❑Hearing Loss ❑Drainage
❑Infections #/yr_____ ❑Dizziness/Vertigo
❑Ringing ❑Fullness ❑Popping Sensations

Nose & Sinus
❑Nasal Congestion ❑Nasal Drainage ❑Post-Nasal Drip
❑Facial Pain ❑Nose Bleeds ❑Nasal Obstruction

Mouth & Throat
❑Hoarseness ❑Change in Voice ❑Snoring
❑Ulcers ❑Sore Throat ❑Witnessed Apnea
❑Recurrent Throat Infections #/yr_____
❑Difficulty Swallowing ❑Painful Swallowing
❑Sense a "lump" in throat

Neck
❑Neck Mass ❑Pain ❑Lymphadenopathy

Endocrine/Glands
❑Change in thirst/appetite ❑Feel cold all the time
❑ Neck has enlarged ❑Feel hot all the time
❑Change in Appetite ❑Weight Loss

Allergy
❑Food intolerances ❑Itchy/watery eyes
❑Mold Allergy ❑Seasonal allergies
❑Receive Allergy Shots ❑Sneezing
❑Allergy symptoms all year long

Pulmonary
❑Non-productive cough ❑Wheezing
❑Productive cough ❑Shortness of Breath
❑Stridor ❑Pneumonia ❑Cough up blood

Cardiovascular
❑Swelling of Ankles/legs ❑Chest Pain
❑Blacking out/fainting ❑Irregular Heartbeat

Stomach/GI System
❑Cough while eating ❑Heartburn/Reflux
❑Nausea ❑Stomach Problems
❑Vomiting

Genito/Urinary
❑Are You Pregnant? ❑Urinate Frequently at Night

MusculoSkeletal
❑Back Pain ❑Muscle Pain ❑Muscle Cramps
❑Bone Pain

Nervous System
❑Balance Problems ❑Numbness ❑Seizure
❑Pass Out ❑Weakness

Integument/Skin
❑ Change in Skin Lesion ❑Form large scars
❑Non-healing Wound ❑Rash

Blood/Lymph Nodes
❑Bleed Excessively ❑Bruise Easily
❑Swollen Glands ❑Frequent Nose Bleeds

Psychiatric
❑Depression ❑Anxiety ❑Excessive Stress

Do you have any of the following symptoms:
❑Spouse/significant other says you stop breathing when sleeping ❑Snore Loudly ❑Dry mouth in the morning
❑Sleepy during the day ❑Uncontrollable sleep attacks ❑Restless sleep
❑Creepy/crawling sensations in legs when trying to sleep ❑Leg kicking while sleeping
❑Wake up feeling paralyzed ❑Hallucinate when waking up/falling asleep
❑Difficulty falling asleep ❑Difficulty staying asleep ❑Waking up too early
❑Worrying at bedtime ❑Take sleeping pills ❑Drink alcohol to help you fall asleep

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Allergy Evaluation Form

ALLERGY TREATMENT HISTORY:

Have you ever been tested for allergies? ❑No ❑Yes
If yes, when and by whom (include address if possible_____
Method used? ❑Prick ❑Scratch ❑Intradermal ❑Blood Test
Were you found to be allergic? ❑No ❑Yes
If yes, to what? _____
Were you treated with allergy shots? ❑No ❑Yes
If yes, for how long and was the treatment helpful? _____

SYMPTOMS:

What are the main symptoms that brought you to us? : _____
_____
_____
How long have these symptoms lasted? _____
Are the symptoms getting: ❑Better ❑Worse ❑Staying the same
Are your symptoms worse in: ❑Spring ❑Summer ❑Winter ❑Fall

Do you have any of the following symptoms? Please check and explain all that apply:

❑No ❑Yes **Cough** ❑Constant ❑Intermittent ❑Daytime ❑Nighttime

❑No ❑Yes **Frequent colds** Occurrences per year: _____

❑No ❑Yes **Sneezing** ❑Seasonal - what season? _____ ❑Related to location - where? _____
What seems to make it worse? _____

❑No ❑Yes **Sore throat** ❑From infection ❑From nasal drainage

❑No ❑Yes **Nasal Drainage** Location: ❑Back of nose ❑Front of nose ❑Both
Color: ❑Cloudy ❑Clear ❑Yellow ❑Green

❑No ❑Yes **Eye Symptoms** ❑Itching ❑Watering ❑Burning ❑Puffiness ❑Dark circles underneath

❑No ❑Yes **Wheezing** ❑With Exercise

❑No ❑Yes **Headache** What part of head? _____ How often? _____

❑No ❑Yes **Asthma** ❑Now ❑As a child ❑Both
Severity: ❑Mild ❑Moderate ❑Severe
Have you ever had to go to the hospital because of your asthma? ❑No ❑Yes

❑No ❑Yes **Ear Problems** ❑Itchy ❑Drainage ❑Infections
❑Ringing ❑Hearing loss ❑Popping ❑Stuffy

❑No ❑Yes **Dizziness** ❑Mild ❑Moderate ❑Severe
How often? _____ How long does it last? _____
How long have you had it? _____

❑No ❑Yes **Loss of smell or taste** Since? _____

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Allergy Evaluation Form

SYMPTOMS:

❑No ❑Yes **Laryngitis** ❑Seasonal ❑With a cold ❑With voice overuse

❑No ❑Yes **Eczema/Chronic Skin Rash** ❑Now ❑As a child ❑Both
Where? _____

❑No ❑Yes **Hives** What is the cause? _____

❑No ❑Yes **Fungus Infection** ❑Athlete's foot ❑Vaginitis ❑Groin Rash

❑No ❑Yes **Itchiness** ❑Roof of mouth ❑Nose ❑Ears ❑Throa ❑Hands

❑No ❑Yes **Gastrointestinal** ❑Bloating ❑Cramping ❑ Constipation ❑Diarrhea

HOME AND WORK ENVIROMENT:

Are your symptoms increased: ❑At work ❑At home ❑No change
Are you exposed to any animals: ❑At work ❑At home ❑Both ❑Neither
If so, what type of animals? _____

How old is your home? _____
How old is your workplace? _____
How long have you lived in Houston? _____
If you have lived in an area other than Houston, where? _____
Since moving to Houston, have your symptoms: ❑Improved ❑Worsened ❑Stayed the same

Please list, if any, a particular room or location where your symptoms occur or seem to worsen.
At home: _____
_____
At work: _____
_____

What is your occupation? _____
What hobbies/Sports do you participate in? _____
What type of heating do you use at home? _____Air conditioning? _____
Heating at work? _____ Air Conditioning? _____
(Example: central-air and heat, fireplace, coal-burning stove, window units, etc.)

Please check all that apply:
At home: ❑Air is too dry ❑Air is too damp ❑Use Humidifier ❑Use air purifier
At work: ❑Air is too dry ❑Air is too damp ❑Use Humidifier ❑Use air purifier

Please list anything at work or home you think you may be allergic to. _____
_____
_____
_____

Do you travel frequently? ❑No ❑Yes
When you travel are your symptoms: ❑better ❑worse ❑stay the same

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Allergy Evaluation Form

SPECIFIC CAUSES OF ALLERGIES:

Mold

How are your symptoms outdoors? ❑better ❑worse ❑stay the same
Do your symptoms increase:
after sunset? ❑No ❑Yes
just before a thunderstorm? ❑No ❑Yes
in dark woodlands? ❑No ❑Yes
around lakes or marshes? ❑No ❑Yes
around farms and barns? ❑No ❑Yes

How are your symptoms indoors? ❑Better ❑Worse ❑Stay the same
Do you have indoor green plants? ❑No ❑Yes If yes, how many? _____
What rooms? _____
Do you have old books or stacks of magazines and newspaper? ❑No ❑Yes
Do your symptoms increase:
in storage areas? ❑No ❑Yes
in certain rooms? ❑No ❑Yes If yes, which rooms? _____
Do you use pillows or comforters with down or feathers? ❑No ❑Yes
Do you use open fireplaces? ❑No ❑Yes

Pollen

Do your symptoms increase when going outside in the morning? ❑No ❑Yes
Do your eyes itch and form tears when your symptoms are bad? ❑No ❑Yes
Do you have repeated bouts of sneezing? ❑No ❑Yes
In which months are your symptoms worse? ❑Summer ❑Spring ❑Winter ❑Fall
Best? ❑Summer ❑Spring ❑Winter ❑Fall
Do you have any itching of the skin with your symptoms? ❑No ❑Yes
Name any plant that you suspect gives you trouble: _____
Do your symptoms improve when you go away on vacation? ❑No ❑Yes
List any areas of the country where your symptoms:
seem to improve: _____
seem to get worse: _____
Do you get itching in the back of your throat? ❑No ❑Yes

Perennials

Is your house difficult to dust because of knickknacks? ❑No ❑Yes
Do you have overstuffed or antique furniture? ❑No ❑Yes
Does your nose congest shortly before going to bed? ❑No ❑Yes
Do your symptoms increase:
in public buildings? ❑No ❑Yes
in motels? ❑No ❑Yes
in airplanes? ❑No ❑Yes
Does household cleaning bring on or worsen your symptoms? ❑No ❑Yes
List any animals you have in or around you house: _____
_____
Do your symptoms increase in public libraries or bookstores? ❑No ❑Yes
Did the previous occupant of your home have pets? ❑No ❑Yes

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Allergy Evaluation Form

Food

Do your symptoms occur without regard to season?	❑No	❑Yes
Do they occur anywhere in the country?	❑No	❑Yes
Do you have itching of your throat?	❑No	❑Yes
Do you get frequent headaches?	❑No	❑Yes
Do you seem to get frequent body rashes?	❑No	❑Yes
Do you get cramping, bloating, or diarrhea often?	❑No	❑Yes
Do you tend to re-taste food eaten earlier?	❑No	❑Yes
Do your symptoms often wake you up at night?	❑No	❑Yes
Do you sleep excessively after meals?	❑No	❑Yes
Do your feet or hands swell?	❑No	❑Yes
How long do your symptoms usually last?	❑Minutes	❑1-4 hours ❑5 hours or more

Describe any reaction you think might be related to a food:

Food _____ Reaction _____
Food _____ Reaction _____
Food _____ Reaction _____
Food _____ Reaction _____
Food _____ Reaction _____
Food _____ Reaction _____

Environmental Exposure

Please check any of the following that aggravate your symptoms:

❑Paint fumes	❑Newspaper	❑Cooking Odors
❑Road dust	❑Mowing lawn	❑Wool
❑Air pollen	❑Smoke	

Cosmetics (please indicate brand names)

❑Bath Powder _____
❑Bath Soap _____
❑Shampoo _____
❑Hair Conditioner _____
❑After Shave _____
❑Shaving Cream _____
❑Toothpaste _____
❑Deodorant _____
❑Cold Cream _____
❑Hair Coloring _____
❑Perfume/Cologne _____
❑Washing detergent _____
❑Fabric Softener _____

Animals and Birds (please indicate type)

❑Dog (inside or outside) _____
❑Birds (parakeets, finches, etc.) _____
❑Cat (inside or outside) _____
❑Gerbils, hamsters, mice, etc. _____

Feather Pillows? ❑Yes ❑No
Down Jackets, comforters, sofas, etc.? ❑Yes ❑No _____
Mattress & spring (age and type) _____