



Acknowledgment of Receipt of Notice of Privacy Practices and Consent for Treatment, Payment and Healthcare operations

My signature on this form indicates that I have received the Notice of Privacy Practice for the Oklahoma Institute of Allergy & Asthma.

If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the Notice of Privacy Practices.

I also consent to the use and disclosure of my protected health information for my treatment, payment and operational use.

Name of Patient: _____ Date: _____
(Printed)

Name of Personal Representative: (if different from above) _____
(Printed)

Signature: _____

Relationship of above signature to patient: (please circle one)

Self Mother Father Guardian



1810 East Memorial Road, Oklahoma City, OK 73131 | P 405.607.4333 | F 405.607.4404

Patient Demographics

Name: _____ DOB _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Gender: _____ Social Security Number (required): _____

Marital Status: (please circle one)

Single Married Divorced Widowed Separated

If student, name of school/college: _____

City: _____ State: _____ Fulltime or Part-time

Patient's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parents Name: _____

Employer: _____ Work Phone: _____

Whom may we "Thank" for referring you? _____

Emergency Contact Person: _____ Phone number: _____

Responsible Party: _____ Phone number: _____

Name of Person on This Account: _____
Relationship to Patient: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Driver's License Number: _____ State: _____ DOB: _____
Employer: _____ Occupation: _____
Social Security Number (required): _____ Work Phone: _____
Is this person currently a patient in our office? Yes or No

Insurance Information:

Name of Insured: _____ Relationship to Patient: _____
DOB: _____ SSN: _____ Date Employed: _____
Name of Employer: _____ Work Phone: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Insurance Company: _____
Group Number: _____ Policy/ID Number: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Annual Deductible: _____ Amount Used: _____ Max Annual Benefit: _____

Do you have any additional insurance? Yes or No

If yes, please complete the following information.

Name of Insured: _____ Relationship to Patient: _____
DOB: _____ SSN: _____ Date Employed: _____
Name of Employer: _____ Work Phone: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Insurance Company: _____
Group Number: _____ Policy/ID Number: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Annual Deductible: _____ Amount Used: _____ Max Annual Benefit: _____

I authorize release of any information concerning me (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor.

All Charges not paid in full by insurance and/or patient after 90 days will be sent to collections unless other payment arrangements have been made.

Signature of patient or parent, if minor

Date



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Patient Questionnaire

Please read carefully and complete this questionnaire. Accuracy and thoroughness are essential. Print all answers legibly. Answers should be your own thoughts and experiences, not just based on previous results of allergy testing in the past. Please circle or fill in the blanks accordingly. This must be completed prior to your visit. **All information will be considered confidential.**

Patient's Name: _____ Date of Birth: _____

Name of patient's physician: _____

Physicians Telephone number: _____

NASAL HISTORY: (Circle all the apply)

Nasal symptoms you currently or have previously had problems with: itch, sneeze, running down back of throat, running out of nose, clear | watery | white | brown | yellow | green discharge, congestion, poor sense of smell, snoring, recurrent sinus infections requiring antibiotics (how many antibiotics per year?), nasal surgery, nose surgery, nose bleeds, nasal trauma.

When did it begin? _____ How often does it occur? _____
(year) (times per day, week, etc.)

Worse: day | night How long does it last? _____
(hours, days, etc.)

Worse: indoors | outdoors

Circle the months that are the most severe:

January | February | March | April | May | June | July | August | September | October | November | December

What do you think makes it better? _____

Medications presently used to control problem (s): _____

Are these effective? _____

Do you use over the counter nasal sprays like Afrin, Oxymetazoline, or Neosynephrine? Yes|No

Seriousness of symptoms has caused: absence from school, inability to sleep, inability to exercise, loss of appetite, nervousness, inability to participate in normal age-appropriate activities, other: _____

New environmental factors / exposures (pets, renovation, water leak, etc.) at home or at work? _____

NASAL TRIGGERS: (Circle all the apply)

Irritants: Cleaning products, detergent, cooking odor, perfume, powder, tobacco smoke, other smoke:
moth balls, motor fumes, paint lacquer, wax, glue, insect spray, fertilizers, ammonia, room deodorants, chemicals, Clorox, other: _____

Toiletries: Soap, shampoo, shaving cream, after shave, spay deodorant, hair spray, hair tonic, hair dye, hand cream, make-up, toothpaste, denture cream, mouthwash, nail polish, other: _____

Pets: Dog, cat, bird, horse, hamster, rabbit, other: _____
Is your condition worse around pets? (Specify) _____

Weather: hot, cold, humid, damp, pollution, smog, sunlight, air conditioning, change in temperature, rain, or other: _____

Emotion: crying, laughing, nervousness, happiness, other: _____

Infections: colds, sinus, ear, skin, other: _____

Do you also have problems with: (please circle all that apply)

Eyes: tearing, burning, itching, pain, redness, discharge, puffiness, infections, blurring of vision, dryness or other: _____

Ears: pressure, itchiness, drainage, bleeding, infections (how many total) _____, age of infections _____, any ear tubes _____, hearing loss, swelling, other: _____

Tongue: swollen, sore, itching, coated, trouble tasting, other: _____

Mouth/throat: itching of roof, repeated tonsillitis, tonsils removed, morning sore throat, bad breath, trouble swallowing, mouth breathing, frequent throat clearing, change in voice, other: _____

CHEST|LUNG HISTORY: (please circle all that apply)

Chest: shortness of breath, wheeze, pain, tightness, cough (dry|wet|junky), cough then wheeze, chest pain, difficulty getting air in/out of the lungs, gradual worsening of symptoms, sudden worsening of symptoms, voice change that occurs with shortness of breath, location of the blockage of air flow (chest or throat), childhood asthma or frequent bronchitis

Does albuterol, ventolin, proventil, maxair, or foradil help? _____
How quickly does it help? _____
How often and how much do you use? _____

How often do you get oral steroids for chest or lung issues (orapred, prednisone, prelone)? _____

Does drinking water or relaxing help? _____

Do you or your child cough when being tickled? _____

Do you cough when laughing or talking? _____

Do you cough worse at night or daytime? _____

Do you cough worse from midnight to 6am? _____

Or within an hour or so of lying down or getting up? _____

Do you have heartburn, reflux of acid (sour taste), or vomit burps? _____

How often? _____

Do you prefer to use an inhaler or nebulizer? _____ Why? _____

With the nebulizer/inhaler, do you use a mask? _____

Do you use a spacer? _____

Do you check peak flows? _____ If yes, what are they? _____

Do you use an asthma action plan? _____

How many emergency room visits for asthma type symptoms – pneumonia/shortness of breath/bronchitis/or wheezing in the past? _____

How many times in the last 1 year? _____

How many regular doctor visits last year? _____

How many hospitalizations ever? _____ Last year? _____

Have you been in the intensive care unit? _____

Have you ever required a tube ventilator to help you breath? _____

SKIN HISTORY: (Non Hive)

Circle factors which may affect your skin problems:

New Clothing: wool, silk, sweater, coat, shoes, dry-cleaning clothes, starched clothes, other: _____
(unwashed) _____

In Contact with: poison ivy, cut grass, cut flowers, household plants, hay, Christmas trees, plastic, fiberglass, rubber, dust, wool blankets, feather pillows, mattress, overstuffed furniture, rugs, rug pads, stuffed toys, furs, jewelry, shoe polish, other: _____

Exercise: running, jumping, swimming, basketball, skiing, tennis, soccer, other: _____

Any history of eczema | rashes | poison ivy | boils | recurrent infections?

Do foods make the rash worse? _____

How quickly after you eat food does the rash get worse? _____

What else may make the rash worse? (please circle all that apply)

Heat, cold, pressure, scratching, tight clothing, vibration, sunlight, exercise, contact with grass,
Carpet, or other: _____

ENVIRONMENTAL HISTORY: (circle pertinent items and fill in the blanks)

Where do you live?

Apartment, brick house, wood frame house, mobile home, other: _____

Location:

City, suburb, country, farm, near factory, bakery, grain storage, swamp, poultry yard, barn,
Other: _____

Type of heating:

Forced air, radiator, electric, heat pump, filtered air, gas, oil, space heater, wood burning stove,
Other: _____

Air conditioning:

Window unit, central, open window, swamp cooler, other: _____

Do you use a vaporizer or central humidifier? Yes or No

Do you have an air cleaner? Yes or No

Do you have a basement or attic? Yes or No

Your bedroom:

Carpeting? Yes or No

Dust catching drapes/shades on windows? Yes or No

Are there plastic (allergen or leak proof) covers on mattress? Yes or No

Are there plastic covers on the pillows? Yes or No

Are there plants? Yes or No

Do you have stuffed animals in your bedroom? Yes or No

Upholstered furniture in the bedroom? Yes or No

Do you have family members/friends who visit frequently who smoke? Yes or No

Animal contacts: dog | cat | bird Other: _____

Inside the home? Yes or No Outside the home? Yes or No

How often do you come in contact with these animals? _____

Do you live near any areas of heavy smog or pollution? _____

Is visible mold or mildew (musty odor) a problem in your home? Yes or No

Are you exposed to any chemical, organic dust etc. at home or at work? Yes or No

Problem worse when: (circle all that apply)

Indoors, outdoors, at home, bedroom, living room, kitchen, basement, attic, garage, at work, in
car, in boat, exercising, at beauty shop, at school, driving in traffic, sweeping, house cleaning,
making beds, around fans, around humidifier, around vaporizer, around open windows, around
heating ducts, on windy days, taking hot or cold baths, swimming in chlorinated water, in musty
places, wearing tight clothing, other: _____

MEDICATION HISTORY:

Please indicate all allergy or asthma medications you or your child has received. How often and how recently? _____

Singulair: Yes|No|N/A Did it help? _____

Gamma globulin: Yes|No|N/A Did it help? _____

Do you use herbal medications? Yes|No|N/A
If so, which ones and how much? _____

Herbals|Supplements? Yes|No|N/A

PAST MEDICAL HISTORY: (please circle all the apply)

Childhood: breast fed, bottle fed, colic, spitting up, gas, croup, hives, frequent colds, other: _____

Other: emphysema, tuberculosis, cancer, diabetes, high blood pressure, heart failure, coronary artery disease, cataracts, glaucoma, osteoporosis, other: _____

List any medical conditions other than those stated above for which you have been treated: _____

Hospitalizations: _____

Reason: _____

Surgeries: _____

Reason: _____

ALLERGIES:

Medications: _____

Types of reactions: _____

Foods: _____

Types of reactions: _____

Do symptoms occur every time you eat the food? _____

How long after eating the food do you have a reaction? _____

Insect bite or sting: _____

Types of reactions: _____

Unknown cause: _____

Types of reactions: _____

Previous allergy evaluation:

Physician	Date	Shots Y/N	Did Shots Help? Y/N
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations:

Please bring a copy of your current immunizations record with you.

List any immunizations you/your child had reactions to: _____

SOCIAL HISTORY:

Do you smoke currently? Yes or No How many packs per day? _____

Any tobacco exposure in the home? Yes or No

Have you ever smoked? Yes or No

Start date: _____ Stop date: _____

Do you drink alcohol? Yes or No Socially only? Yes or No

How much? _____

Do you use drugs other than prescribed by a physician? Yes or No (Substance abuse)

HOBBIES:

Yours: _____

Family's: _____

Recent travel: _____

FAMILY HISTORY:

From the list below, please state which family members have:

Asthma, hay fever, eczema, recurrent infections of the skin/sinuses/ears/lungs, emphysema,
Cystic fibrosis, nasal/sinus polyps, lung problems other than asthma, migraines, thyroid
problems, drug allergy, food allergy, other: _____

Father: _____

Mother: _____

Brothers/Sisters: _____

Grandparents: _____

Children: _____

Any other illnesses run in the family? _____

REVIEW OF SYMPTOMS: (please circle all that apply)

General: fever/chills, unintentional weight loss (how many pounds, last 6 months?) _____

Fatigue, insomnia, loud snoring/stopping breathing while sleeping, excessive daytime sleepiness

Heart: Chest pain, murmurs, fainting, hereditary abnormality, high blood pressure

Joints: pain, stiffness, swelling, fever, other: _____

Menses: regular, irregular, discharge, pain, itch, cramps, infections, last period: _____ (date)

Are you pregnant? Yes or No

Taking birth control pills? Yes or No

Urine: pain, burning, frequent urination, bladder infection, recurrent infection, itching, chills, fever

Thank you for your cooperation! Accurate completion of the questionnaire will save you time the day of your appointment!

If you do not have hives, please check this box, and leave this section blank.



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Hives Questionnaire

Patient Name: _____ Date: _____

General Features:

Date of onset of hives? _____

Frequency of attacks (ie. Daily, weekly, etc.) _____

Time of day when symptoms are most severe? _____

Mornings _____

Daytime _____

Evenings _____

After meals _____

Other _____

Parts of body usually affected first, if any?

Seasonal:

Do hives occur more frequently during certain times of the year?

Winter _____

Cold exposure (wind, swimming, etc) _____

Spring (pollens) _____

August-September (ragweed) _____

Summer _____

Physical:

Do any of the following produce hives?

Heat exposure _____

Exercise _____

Sunlight Exposure _____

Rainy or wet periods _____

Damp rooms/areas (molds) _____

Bathing or showering _____

Pressure or prolonged sitting _____

Vibration _____

Hives Questionnaire (cont.)

Rubbing or scratching _____
Friction, clothing contact _____

Contact:

Exposure to animals _____
What types? _____
Exposure to fumes _____
What types? _____
Cosmetics, soaps, or detergents _____
What types? _____

Hormonal:

Related to stress _____
Menstrual periods _____
Pregnancy _____

Occupational – Recreational History:

Do hives appear to occur in relation to any of the following?

Indoors only or predominantly _____

Rooms/locations in particular:

Workshop _____
Basement _____
Attic _____
Other _____

Outdoors only or predominantly _____

At work predominantly _____

At home predominantly _____

At another location _____

Where? _____

During work week predominantly _____

On weekends predominantly _____

Improve while away on vacation _____

Related to recreational activities _____

Which types? _____

Occur with housework _____

History of Infections:

Have you recently had any of the following infections or symptoms of infections?

Sore throat/strep throat _____

Swollen lymph glands _____

Mononucleosis _____

Impetigo/skin infections _____

Jaundice/hepatitis _____

Pneumonia _____

Yeast infection _____

Hives Questionnaire (cont.)

Painful urination/urinary tract infection _____
 Fungal infection of skin, hair, nails _____
 Tooth/gum infection _____
 Other: _____

History of Allergy or Allergic Symptoms:

Do you have any of the following types of allergy or allergic symptoms?

Hay fever/sinus congestion _____
 Wheezing/asthma _____
 Itching of skin _____
 Eczema _____
 Excessive tearing _____
 Nausea/abdominal pains/diarrhea _____
 Swelling of lips/mouth after eating _____
 Known allergic agents _____
 Previous skin testing for allergies _____
 Family history of above problems _____

Medications:

List all prescriptions drugs taken in the last year, including those discontinued. Please include any topical (creams) and injected medication:

List all over the counter drugs taken in the last year. Please include cosmetics in this list.

Check list of medications used in the last year:

Antibiotics	_____	Pain Killers	_____
Antidepressants	_____	Penicillin	_____
Antihistamines	_____	Sedatives	_____
Cortisone	_____	Seizure medication	_____
Cough medication	_____	Sleeping Pills	_____
Decongestants	_____	Sulfa drugs	_____
Diet pills	_____	Suppositories	_____
Digitalis	_____	Tetracycline	_____
Diuretics	_____	Thyroid pills	_____
Douches	_____	Tonic (quinine)	_____
Hormones	_____	Tranquilizers	_____
Laxatives	_____	Vaginal medication	_____
Mouth washes	_____	Water Pills	_____
Muscle relaxants	_____	Vitamins	_____
Oral contraceptives	_____		

Hives Questionnaire (cont.)

For which of the following conditions have you taken medication in the last year?

Acne	_____	Headaches	_____
Allergy	_____	Heart conditions	_____
Anemia	_____	Hemorrhoids	_____
Asthma	_____	Hypertension	_____
Bowel disorder	_____	Insomnia	_____
Colds	_____	Kidney disorder	_____
Constipation	_____	Menopause	_____
Cough	_____	Menstrual disorder	_____
Depression	_____	Nervousness	_____
Diabetes	_____	Pinworms	_____
Diarrhea	_____	Rectal disorder	_____
Epilepsy	_____	Seizures	_____
Fungal infection	_____	Sinus trouble	_____
Gall bladder	_____	Thyroid disorder	_____
Glaucoma	_____	Urinary infection	_____
Gout	_____	Vaginal infection	_____

Foods:

Have you noticed that particular foods cause hives, swelling of the lips, tongue, sinus congestion, nausea, abdominal pain, or difficulty breathing? Please list foods and accompanying symptoms:

Are any of the above symptoms caused by the following foods?

Beer	_____	Milk	_____
Bread	_____	Mints	_____
Cake	_____	Nuts	_____
Cheese	_____	Pickles	_____
Cider	_____	Sausage	_____
Coffee	_____	Seafood	_____
Eggs	_____	Strawberries	_____
Grapes	_____	Tomatoes	_____
Ham/pork	_____	Wine	_____
Ketchup	_____	Vinegar	_____

Hives Questionnaire (cont.)

Treatment:

Please indicate the treatments that have been used for your hives in the past. Use the following scale to score the response to each type of therapy:

0 – No response; 1 – Slight response; 2 – Moderate response; or 3 – Complete clearing.

Therapy	Response
Antihistamines	
_____	_____
_____	_____
_____	_____
_____	_____
Steroids (oral or injected)	
_____	_____
Epinephrine _____	_____
Ephedrine _____	_____
Dietary elimination - type	
_____	_____
_____	_____
_____	_____
Antibiotics	
_____	_____
_____	_____
_____	_____
Other – please specify	
_____	_____
_____	_____
_____	_____

If you do not have headaches, please check this box, and leave this section blank.



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Gilbert Headache Questionnaire

Patient Name: _____ Date: _____

Please check the following that apply to you.

- _____ Do you have an idea of what may be causing your headache? (whiplash, diabetes, high blood pressure, eye strain, etc.?)
- _____ Did this type of headache ever occur before?
- _____ Is this headache pain so intense that sometimes it becomes unbearable?
- _____ Do your headaches occur during stressful tension or nervousness at home, at work, or during social occasions?
- _____ Do your neck, shoulder muscles, or head junction feel tight and painful during the headache?
- _____ Is your headache pain dull and steady, like an intense constant pressure?
- _____ Does your headache feel like a tight band around your head?
- _____ Do you usually have one or more headaches per week?
- _____ Do your headaches occur during the day?
- _____ Does your mother, father, or any blood relative have similar headaches?
- _____ Does exertion (lifting, running, straining, sex) affect your headache?
- _____ Does nausea and/or vomiting occur before or during your headache?
- _____ Do you have any changes in vision (flashing lights, sensitivity to light, spots, blurred vision, etc.) before or during your headache?
- _____ Does your headache usually start on one side of the head?
- _____ Does your headache throb and pulsate or feel like it is pounding?
- _____ Do your headaches usually occur during the night or upon awakening?
- _____ Do your headaches usually occur during weekends and holidays?
- _____ (Females only) Is your headache associated with your menstrual periods?
- _____ Do you have watering of the eye on the affected side of the headache?
- _____ Do alcoholic drinks cause or aggravate your headaches?
- _____ Does chocolate, cheese, milk, nuts, Chinese food, or any other food cause or worsen your headaches?
- _____ Do you have any hearing problems – noise, drainage, stuffiness in either ear?
- _____ Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes during your headaches?
- _____ Do you have any facial pain, aching jaws, stuffiness or congested sinuses along with your headaches?
- _____ Has it been over eighteen (18) months since you last visited a dentist?
- _____ Have you had tests for headaches? (x-ray, brain scan, injections, etc.)
- _____ Have you used any previous headache medication? (please list them on the back of this form)