Asthma & Allergy Centers of Central Michigan

RAMESH B. AVULA, M.D.
Diplomate of the American Board of Allergy and Immunology

PATIENT INFORMATION FORM

NAME: ______________________ HOME PHONE ______________________

CELL PHONE ______________________

HOME ADDRESS ______________________ DATE OF BIRTH ______________________

CITY ______________________ SEX M F RACE: Asian Black White Native Hawaiian American Indian Other

STATE ______________ ZIP CODE ______________

ETHNICITY: Hispanic Non Hispanic Unknown

EMAIL ______________________ PREFERRED LANGUAGE: ______________________

SPOUSE'S NAME ______________________ WORK PHONE ______________________
(Parent if Minor Patient)

SOC. SECURITY # ______________ / ______________ REASON FOR VISIT ______________________
(Parent if Minor Patient) DOB of Subscriber

EMPLOYED BY ______________________ WORK PHONE ______________________
(Parent if Minor Patient)

NEAREST RELATIVE NOT LIVING WITH YOU ______________________ PHONE ______________________

REFERRED BY ______________________ PHONE ______________________

WHO IS RESPONSIBLE FOR PAYING THIS BILL? ______________________

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

______________________ ______________________
Signature Date

______________________ ______________________
Parent (if minor) Date

DATE ______________________________

PATIENT ______________________________

EMPLOYER ______________________________

CLAIM GROUP ______________________________

SS#/ID # ______________________________

FOR MEDICARE PATIENTS ONLY

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICE RENDERED.

I request that payment of authorized Medicare benefits be made to me or on my behalf to the physician for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

______________________________ RECEP. INITIALS __________

PATIENT SIGNATURE

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NAME: ______________________ DATE: ______________________

AGE: ______________________ REFFERING PHYSICIAN: ______________________

D.O.B. ______________________ PRIMARY PHYSICIAN: ______________________

S M W D TEL #: ______________________

Patient: Please fill out this side:	Physician notes

The main problems for coming here are:

____

A. Nose

- ☐ Congestion
- ☐ Drainage
- ☐ Polyps
- ☐ Snoring
- ☐ Sneezing
- ☐ Sniffles
- ☐ Trauma
- ☐ Mouth breathing
- ☐ Itching
- ☐ Frequent colds
- ☐ Surgery

B. Sinus

- ☐ Infections
- ☐ Headaches

C. Eyes

- ☐ Redness
- ☐ Tearing
- ☐ Blurring
- ☐ Itching
- ☐ Discharge
- ☐ Pain
- ☐ Watering
- ☐ Puffiness
- ☐ Double vision

D. Ears

- ☐ Plugging
- ☐ Infections
- ☐ Discharge
- ☐ Pain
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Itching
- ☐ Tube placement

E. Throat

- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Itching
- ☐ Swollen glands
- ☐ Postnasal drip
- ☐ Frequent clearing

F. Chest

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheeze
- ☐ Sputum
- ☐ Chest congestion

G. Skin

- ☐ Hives
- ☐ Redness
- ☐ Giant swellings
- ☐ Itching
- ☐ Rashes
- ☐ Eczema
- ☐ Dryness

These symptoms occur:

- ☐ Spring ☐ Summer ☐ Fall ☐ Winter
- ☐ Days or weeks at a time
- ☐ All the time
- ☐ At home
- ☐ All day ☐ Worse at night or morning

Symptoms are made worse by:

- ☐ Colds (Virus)
- ☐ Tobacco smoke
- ☐ Exercise
- ☐ Raking leaves
- ☐ Moving grass
- ☐ Dusting or cleaning
- ☐ Exposure to pets
- ☐ Stress
- ☐ Foods
- ☐ Damp Basement
- ☐ Weather Changes
- ☐ Cold air
- ☐ Heat
- ☐ Humidity
- ☐ Air conditioner
- ☐ Perfumes/scents
- ☐ Hairsprays
- ☐ Paints/chemicals
- ☐ Latex
- ☐ Others

All Current Medicines:

________________ ___ times /day
________________ ___ times /day
________________ ___ times /day
________________ ___ times /day
________________ ___ times /day

Previous allergy or asthma medication (including OTC):

________ ☐ helped ☐ no help ☐ side effects
________ ☐ helped ☐ no help ☐ side effects
________ ☐ helped ☐ no help ☐ side effects
________ ☐ helped ☐ no help ☐ side effects
________ ☐ helped ☐ no help ☐ side effects

Allergy Survey:

1. Occupational History

Employer ________________
Specific job ________________
Difference in symptoms between work and home
____
Change in symptoms on vacation ________________
____

2. Previous Allergic Investigation

By whom ________________ When ________
Results of tests ________________
____
Immunotherapy (shots) given for ________________
____
Top dose ________________
Duration ________________
Results ________________
Reason treatment stopped ________________
____

Physician notes

3. Current environment

☐ City ☐ Town ☐ Country
☐ House ☐ Apartment ☐ Mobile Home

Age of House _____ Occupied for _________

Basement ☐ Yes ☐ No ☐ Damp ☐ Dry

Heat ☐ Forced air ☐ Other

Air cond ☐ Yes ☐ No ☐ Central ☐ Room

Humidifier ☐ Yes ☐ No ☐ Central ☐ Unit

Dehumidifier ☐ Yes ☐ No

Bedroom

Sleeps on: ☐ Mattress ☐ Waterbed

Pillow: ☐ Foam ☐ Feather ☐ Plastic covers

Stuffed animals ☐ Yes ☐ No

Floor: ☐ Carpet ☐ Wood ☐ Linoleum

Living Room

Floor: ☐ Carpet ☐ Wood ☐ Linoleum

Symptoms increased in any location in house

____

____

4. Pets

☐ Indoors ☐ Outdoors

What kind? ________________________________

How long have you had pets? ________________

5. Smoking Exposure

☐ Active ☐ Passive

6. Allergy to Food

Food ____________ Reaction ________________

Food ____________ Reaction ________________

7. Allergy to Medications

Drug ____________ Reaction ________________

Drug ____________ Reaction ________________

8. Insect Stings	**Yes**	**No**
Local swelling	☐	☐
Hives	☐	☐
Wheezing	☐	☐
Passing out	☐	☐

9. Contact skin reactions, i.e., poison ivy/ others

____

____

Physicians Notes:

Past Medical History

Hospitalizations Age or year

Surgeries ________ for ________
________ for ________
________ for ________

Emergency Visits _____ in past year
_____ times in past 5 years

No. of sinus infections in the past year _____
No. of ear infections in the past year _____
No. of pneumonias during lifetime _____
Days of school or work missed in past year _____

Other chronic health conditions:

☐ Heart disease ☐ Hypertension ☐ Diabetes
☐ Gastritis/ulcer ☐ Others ________

FOR INDIVIDUALS UNDER AGE 18 ONLY

Birth weight _______ lbs. _______ ozs.
Complications during pregnancy/delivery ________

Postnatal:
☐ Respiratory distress ☐ Infection ☐ Jaundice
☐ Anemia ☐ Congenital anomalies
☐ Heart murmur

Growth and Development:
☐ Breast fed ☐ Formula fed ☐ Tolerated well
☐ Colic

Immunizations
☐ DPT ☐ Polio ☐ MMR ☐ HIB

☐ Hepatitis B ☐ Pneumovax/Prevnar ☐ Influenza

FAMILY HISTORY

☐ Asthma ☐ hay fever ☐ Sinusitis ☐ Eczema
☐ Hives ☐ Food allergy ☐ Cystic fibrosis
☐ Emphysema

Social History:

Level of education ________
Current occupation ________
Smoking: Current ______ Past ______
Drug/Alcohol use ________

Review of Systems: (check if present)

☐ Fever
☐ Weight loss/night sweats
☐ Skin problems besides eczema
☐ Joint swelling or pain
☐ Anemia
☐ Throat infections
☐ Irregular heart beats/palpitations
☐ Stomach upset
☐ Urinary or bladder problems
☐ Nerve or psychiatric problems
☐ hormone problems (such as hot flashes, etc.)

Name of the person filling out this form (print):

____

Relationship if not the patient:

____

Physician notes: