Asthma, Allergy & Sinus Center

3600 Leonardtown Rd., Ste 103, Waldorf MD, 20601

Welcome to our practice! We are so pleased that you have selected our practice for your care. We have prepared this packet of information and patient forms in order to help make your first visit a convenient and pleasant experience. This initial appointment can be lengthy. Please try to arrive 30 minutes early to complete your registration process. Please allow up to three (3) hours so that you will not feel rushed and so that your consultation can be completed. At this appointment, the doctor will take a detailed history from which they will determine whether skin testing and/or breathing tests are appropriate. If so, the testing will also be done at this time, and the doctor will discuss the results and treatment options with you.

We ask that you wear a short sleeved shirt and STOP taking the following medications five (5) days prior to your first appointment:

- **Prescription antihistamines** such as desloratine (Clarinex), levocetirizine (Xyzal), hydroxyzine (Atarax) or cyproheptadine (Periactin).
- **Over-the-counter antihistamines** such as Benadryl (dipenhydramine), Claritin (loratadine), Chlor-Trimeton (chlorphenamine), Zyrtec (cetirizine), Allegra (fexofenadine), Nyquil, or any other over the counter medicine that contains an "antihistamine" in the active ingredients.
- **Nasal antihistamine spray** azelastine (Astelin), Patanase, Astepro, Dymista

If you do not know whether a medication you are taking is an antihistamine, please call our office, your pharmacist, or your family doctor. If you take a "rescue" inhaler (Proventil, Albuterol) for your asthma, try not to use it for four (4) hours prior to your appointment. Do not discontinue any other regular medications. We also ask that you **bring all medications/inhalers** you are currently taking. For the comfort of our other allergy patients, we also ask that you refrain from wearing perfumes or colognes.

It is important that you bring with you: your **referral** (if required) from your primary doctor, your **photo ID**, your **insurance card(s)**, and any **co-pay** that is required by your insurance plan. If your insurance plan requires a referral, it is YOUR responsibility to obtain the referral and present it for each visit. **If no referral is received, we will reschedule your appointment.**

It is the practice of this office to confirm appointments up to one week prior to your scheduled date. We may leave a message on a machine if we reach the voicemail of the number you have provided. If this is not acceptable, please notify us of an alternate means to contact you. If for any reason you are unable to keep this appointment, we ask that you call the office as soon as possible. All No Call/ No Show visits are subject to a $45.00 fee.

If you have any questions regarding your appointment, please call this office.
Please retain this letter for your information.

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PATIENT REGISTRATION

LAST NAME _____ **FIRST NAME** _____ **MI**_____

ADDRESS _____ **CITY**_____**STATE**_____ **ZIP**_____

DATE OF BIRTH _____ **SEX**_____ **MARITAL STATUS** _____ **SS NUMBER** _____

ETHNICITY _____ **LANGUAGE** _____ **RACE** _____

PRIMARY PHONE: _____ **Home Cell** **SECONDARY PHONE:** _____ **Home Cell Work**

EMAIL _____ **EMPLOYER** _____ **OCCUPATION** _____

****MAY WE LEAVE MESSAGES ON ANSWERING MACHINE? HOME?** _____ **CELL?** _____ **WORK?** _____

REFERRED BY_____ **PCP** _____ **PHONE** _____

PHARMACY NAME _____ **PHONE**_____ **LOCATION**_____

PRIMARY INSURANCE

INSURANCE CO. NAME _____

POLICY NUMBER _____

GROUP NUMBER _____

POLICY HOLDER _____ **DOB** _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S SS NUMBER _____

SECONDARY INSURANCE

INSURANCE CO. NAME _____

POLICY NUMBER _____

GROUP NUMBER _____

POLICY HOLDER _____ **DOB** _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S SS NUMBER _____

IF THE PATIENT IS A MINOR, PLEASE LIST BELOW THE PERSON WITH WHOM THE CHILD LIVES:

NAME _____ **RELATIONSHIP**_____

PRIMARY PHONE: _____ **Home Cell** **SECONDARY PHONE:** _____ **Home Cell Work**

PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY OR IF WE ARE UNABLE TO REACH YOU:

NAME _____ **RELATIONSHIP**_____

HOME PH _____ **CELL PH** _____ **WORK PH** _____

ASSIGNMENT OF BENEFITS/CONSENT FOR RELEASE OF RECORDS

I, _____, authorize the payment of any and all insurance and/or government benefits directly to AASOM and/or any of their employed associates for services rendered. I authorize the release of any medical information necessary for treatment, payment and/or healthcare operations. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not covered by the insurance carrier. In the event of collection efforts, my financial responsibility includes, but is not limited to, collection fees (up to 35%), court costs and attorneys' fees.

I, _____, am aware of the HIPAA and Privacy Policies of AASOM. A copy has been made available to me.

____ Copy Received ____ Copy Declined

SIGNATURE _____ **DATE**_____

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NEW PATIENT – MEDICAL HISTORY

NAME _____ **DOB** _____ **TODAY'S DATE**_____

Please describe in a few words, why you are here:

_____

_____

_____

What kind of work do you do? If child, what grade? _____

MEDICATIONS

What medications do you take on a daily or frequent basis?

Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES

List any medications you are allergic to, the nature of the reaction, and how long ago:

Name	Reaction	When	Name	Reaction	When

ENVIRONMENTAL HISTORY

Do you live in a: ___single family house ___townhouse ___apartment ___trailer ___basement
If the patient is a young child, during the day are they: ___at home ___in school ___with a caretaker
Do you have carpet in the bedrooms? Y N
Do you have carpet in most of the house? Y N
Do you have central air conditioning? Y N
If you have a basement, has there ever been any mold damage? Y N
Does anyone in the home smoke? Y N
Do you have, or are you around pets? Y N
List all animals that you are frequently around: _____

ALLERGY HISTORY

Have you ever been diagnosed with asthma, allergic rhinitis (hay fever, "allergies"), or eczema? Y N
When you were a young child did you have asthma, allergies, or eczema? Y N
Have you ever been allergy skin tested? If so, when, and what were you allergic to? _____
Have you ever been on allergy immunotherapy shots? Y N
Have you ever had a reaction to: ___Food ___Latex ___Insect stings?
If you do have allergies, what medications have you tried and did they help? _____

FAMILY HISTORY

Does anyone in your family have asthma, allergies, eczema, or recurrent sinus problems? Y N
If yes, please write who and what _____
What other chronic illnesses run in your family:

- ☐ **Diabetes**
- ☐ **High blood pressure**
- ☐ **Heart attacks**
- ☐ **Heart disease**
- ☐ **Cancers**
- ☐ **Recurrent infections**
- ☐ **Rheumatoid arthritis**
- ☐ **Lupus**
- ☐ **Osteoporosis**
- ☐ **Immune problems**
- ☐ **Cystic fibrosis**
- ☐ **Other : _____**

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PAST MEDICAL HISTORY

What medical problems do you have? _____

Have you ever had surgery? Y N

If yes, for what and approximately when? _____

Have you ever been in the hospital overnight for reasons other than surgery? Y N

If yes, for what and approximately when? _____

Have you ever been to the emergency room for asthma? Y N

If yes, how many times and when? _____

Have you ever had to visit the emergency room for any reason other than those listed above? Y N

If yes, for what and approximately when? _____

Have you ever been hospitalized overnight for asthma? Y N

If yes, have you ever been in the ICU? Y N

If the patient is a child, was the child born premature? Y N

Have you ever been a smoker? Y N

If yes, how many years? How many packs per day? _____

If you have quit, when? _____

REVIEW OF SYSTEMS

Please check any problems you have had recently

GENERAL:
- ☐ Fevers
- ☐ Chills
- ☐ Weight Loss (unintended)
- ☐ Night Sweats
- ☐ Loss of Appetite

EYES:
- ☐ Itch
- ☐ Pain
- ☐ Excessive Tears
- ☐ Dry
- ☐ Loss of Vision

EAR/NOSE/THROAT:
- ☐ Congestion
- ☐ Runny Nose
- ☐ Nosebleed
- ☐ Sore Throat
- ☐ Ear Ringing
- ☐ Ear Pain
- ☐ Hoarse Voice
- ☐ Sinus Issues
- ☐ Loss of Hearing

HEART:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Rapid/Irregular Heartbeat
- ☐ Swelling of Ankles

RESPIRATORY:
- ☐ Cough
- ☐ Wheeze
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Coughing up Phlegm

GI:
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Bitter Taste in Mouth
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Blood in Stool

URINARY:
- ☐ Difficulty urinating

MUSCULOSKELETAL:
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain

SKIN:
- ☐ Rash
- ☐ Itch
- ☐ Hives/Welts
- ☐ Swelling
- ☐ Dryness

NEURO:
- ☐ Headaches
- ☐ Weakness
- ☐ Seizures

PSYCH:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

IMMUNE:
- ☐ Frequent/Persistent Infections
- ☐ Pneumonia greater than 2 times

GYNO:
- ☐ Currently Pregnant
- ☐ Planning pregnancy in near future

What specific questions do you have for the doctor?

_____

_____

_____

_____

Signature: _____ Date: _____