Bloomington-Normal Office 309-452-0995
Springfield Office 217-717-4404
Satellite Offices: Carlinville-Morton-Sherman-Jacksonville-Taylorville

Name _____**DOB**___/___/___ **Age** _____ **Date** _____

Preferred Name_____**Gender**_____**Job** ▢Student ▢N/A_____

Address_____City_____Zip_____

Phone, Cell ( )_____ **Home** ( )_____**Work** ( )_____

E-mail (This is important for us to communicate with you)_____

Communication of Results *Our automated system will contact you by phone or e-mail, when your blood work results have been reviewed (if applicable). A PIN number will be required in order to retrieve your results. You may view all results on the Athenanet Patient Portal. Our staff will assist you in setting up a Portal account.*

Preferred Contact ▢Cell Phone ▢Home Phone ▢ E-mail

May we contact you about your care through your email (including lab results)? ▢Yes ▢No
May we leave messages about your health (including lab results) on the phone? ▢Yes ▢No
May we notify you of clinical research studies conducted by Midwest Allergy Sinus Asthma, SC or our affiliate Sneeze, Wheeze & Itch Associates, LLC in which may be of interest and/or benefit to you? ▢Yes ▢No

Emergency Contact Name _____Phone_____

INSURANCE INFORMATION

Responsible Party ▢Me ▢Spouse ▢Parent/Guardian

Name (if not you)_____Phone ( )_____

Address_____City_____Zip_____

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber DOB		Subscriber DOB	
Subscriber SSN		Subscriber SSN	
Policy No.	Group No.	Policy No.	Group No.
Copay Amt.	Co-Insurance %	Copay Amt.	Co-Insurance %

I, the undersigned, have my insurance with the above named companies, and assign directly to Midwest Allergy Sinus Asthma, SC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid for by insurance. I hereby authorize Midwest Allergy Sinus Asthma, SC, to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that copays are due before each office visit and that payment of services is due within 30 days of the provision of services.

Signature_____ Date_____

Name _____Medical Record Number_____

Referred By ▫Self ▫Friend ▫Ad ▫Doctor _____ City_____

Other Doctors I See Regularly (Name, Specialty):_____

Pharmacy

▫30 Day Preferred, Pharmacy_____Location_____

▫90 Day Preferred, Pharmacy_____Location_____

Preferred Lab Facility_____X-ray Facility_____

Drug Allergies ▫None ▫ I have a list.

Drug:	Reaction:	Estimated Date

Medications Taken Regularly ▫None ▫ I have a list.

Include all over-the-counter, pain or sleep pills, vitamins, herbs, skin creams, drops, inhalers, and birth control.

Medication:	Taken For:	Length of Time:

Medications Taken Occasionally or When Needed ▫None ▫ I have a list.

Include all over-the-counter, pain pills, sleep pills, vitamins, herbs, skin creams, drops, and inhalers.

Medication:	Taken For:	Length of Time:

Immunizations ▢Up-to-Date ▢Not current. ▢ I have a list. List the Year for the Last Shot Received.

Flu Shot_____ Tetanus/Whooping Cough _____ Pneumonia_____
Shingles_____

Medical Problems

Problem	Date	Problem	Date
1		5	
2		6	
3		7	
4		8	

Surgical History

Surgery	Date	Surgery	Date
1		4	
2		5	
3		6	

OB/GYN Pregnancies_____ Live Births_____ **MENSES** ▢ Still Cycling ▢Post-Menopausal

FAMILY HISTORY For Immediate Family (Mother, Father, Siblings, Children)
▢ Asthma ▢ Seasonal allergies or Hay Fever ▢ Food Allergies▢ Insect Allergies
▢ COPD ▢ Atopic Dermatitis or Eczema ▢ Drug Allergies ▢ Angioedema or HAE
▢ Hives ▢ Immunodeficiency ▢ Thyroid Problems ▢ Autoimmune Diseases
▢ Diabetes ▢ Heart Conditions ▢ Arthritis ▢ Other Lung Disease
List Relation and
Disease:_____

SOCIAL HISTORY

Caffeine: ▢ Coffee ▢Soda ▢Tea ▢Energy Drinks, Average Drinks per Day_____

Nicotine: ▢ Never ▢Sometimes ▢Daily Cigarettes, Packs per Day_____▢Vape ▢Chew ▢Cigars

▢Former Smoker, Quit Date_____ Average packs per day?_____ How many years?_____

▢Secondary Tobacco Smoke Exposure, from ▢Spouse ▢Parent ▢Grandparents ▢School ▢Work

Alcohol: ▢ Never ▢Sometimes ▢ Recovering / Alcoholic
▢Daily, Average Drinks per Week_____Type_____

Recreational drugs: ▢ Never ▢Occasional ▢Daily ▢Former Use ▢ Recovering / Drug Addiction

DIETARY INFO

I eat: ▢ Dairy, Milk ▢ Meat ▢ Shellfish ▢ Fish ▢Fruits ▢Green Vegetables

I don't like to eat:_____

What problems are you having?	
How long have you had the problem?	
Things that make it better:	**Things that make it worse:**
What do you expect from this allergy, asthma, or immunology consultation?	

Which of the following are you interested in? ▢Allergy Testing to Environmental Allergens
▢Allergy Testing to Food ▢Food Desensitization ▢Drug Testing ▢Allergy Shots ▢Allergy Drops
▢Chemical Patch Testing ▢Assessment of My Breathing ▢Immune System Tests ▢Weight Loss
▢Other_____

ALLERGY HISTORY

Airborne Allergies ▢Tree Pollen ▢Grass Pollen ▢Weed Pollen ▢Mold Spores
▢Dust Mites ▢Cockroach ▢Pet Dander (List):

Food Allergies ▢Peanut ▢Tree Nuts ▢Milk ▢Eggs ▢Soy
▢Shellfish ▢Fish ▢Wheat ▢Corn ▢Other (List):

Insect Sting Allergy ▢Yes (List): **Latex Allergy** ▢ Yes **Dye-Allergy** ▢Yes (List):

Contact Allergy ▢Poison Oak/Ivy ▢Adhesives ▢Iodine ▢Neomycin ▢Fragrances ▢Other:

Mark if you have any of the following:

Head and Neck ▢Seasonal Allergies or Hay Fever ▢Acute or Chronic Sinusitis ▢Eye Allergies
▢Poor Concentration, Brain Fog ▢Snoring or Sleep Apnea ▢Headaches
▢Post-Nasal Drip ▢Throat Clearing ▢Bad Breath
▢Colored Nose Discharge ▢Hearing Loss ▢Smell Loss ▢Nasal Polyps

Lungs and Chest ▢ Asthma ▢Exercise-Induced Asthma ▢ COPD ▢Other Lung Disease
▢Chest Pain ▢Shortness of Breath ▢Acid Reflux ▢Chronic Cough
▢Wheezing ▢Colored Sputum ▢Waking Up From Sleep for Breathing

Gastrointestinal ▢IBS ▢IBD ▢Diarrhea ▢Constipation ▢Nausea/Vomiting
▢Gas ▢Bloating ▢Weight Change ▢Poor Appetite

Skin ▢ Atopic Dermatitis or Eczema ▢ Contact Dermatitis ▢Other Rash ▢ Chronic Itch
▢ Angioedema or HAE ▢ Hives

Immune System ▢Anaphylaxis ▢ Immunodeficiency ▢Swollen Glands ▢ Autoimmune Diseases

▢ Thyroid Problems ▢Inflammatory Arthritis

RECENT EVALUATION

Have you ever been evaluated by an allergist? ▢No ▢Yes Doctor's Name_____ City_____
Have been skin tested? ▢No ▢Yes
Have you had allergy blood tests? ▢No ▢Yes
Have you been on allergy shots before? ▢Yes ▢No, Any problems? ▢No ▢Yes
Have you seen an ENT surgeon? ▢No▢Yes, Have you had sinus surgery? ▢No ▢Yes
Have you had any recent blood tests? ▢No ▢Yes
Have you had any blood work recently for us to review? ▢No ▢Yes
Have you had any Sinus CT or Chest X-ray? ▢No ▢Yes
Did you request records from another doctor to be sent here? ▢No ▢Yes

ENVIRONMENTAL HISTORY

Years in Illinois_____ Other Places I Have Lived_____

Home ▢House ▢Apartment ▢Mobile Home ▢Assisted-living Age of Home:_____

Foundation: ▢Basement ▢Crawl-space ▢Concrete ▢Water / Mold

Heat/AC: ▢Central ▢Base-board ▢Stove ▢Radiator ▢Window A/C ▢HEPA filter
You windows during nice weather are...? ▢Open ▢Closed

Bedroom: Bed Age_____ Type: ▢Synthetic ▢Water ▢Dust Mite Cover
Pillow Age_____ Type: ▢Synthetic ▢Feather ▢Dust Mite Cover
Age of Floor in Bedroom_____ ▢Rugs ▢Carpet ▢Hard Wood
How many people live in the home?_____ Who lives with patient?_____
Youth: Is there a second parent's home?_____After-school care?_____
How often are bed sheets and pillow cases laundered?_____

Bathing Habits: ▢Showers ▢Bath ▢Daily ▢Less Frequently ▢Morning ▢Evenings

Animal Exposure: ▢At my house ▢At someone else's house ▢Pets allowed in bedrooms
How Many of Each? Dogs_____ Cats_____ Rabbits_____ Hamsters/Gerbils_____
Birds_____ Horses_____ Cattle_____ Pigs_____ Other_____

Other Exposure:
Exposures to allergens at work? _____

Exposures to allergens doing hobbies?_____

Children and Adolescents

School: ▢Homeschool ▢Preschool/Daycare, Grade:_____, Sports/Activities :_____

Birth History

Birth Weight:_____ Full term: ▢No ▢Yes, ▢Vaginal ▢C-Section ▢Birth issues?_____

Breast fed: ▢No ▢Yes, List problems with breastfeeding or formula:_____

Age started solid foods _____, List problems with food/stool:_____

Check the Following: ▢Colic ▢GERD ▢Childhood Eczema ▢Recurrent Ear Infections
▢Strep Throat ▢T&A Surgery ▢Poor Weight Gain with Failure to Thrive.