

## REGISTRATION

### Allergy, Sinus & Asthma Consultants, Inc.

Amit Patel, M.D. Heena Shah, M.D. Aurora Ledezma, PA-C

1282 W. Arrow Highway, Ste 100  
Upland, CA. 91786  
(909) 931-4034 FAX (909) 931-2477

6377 Riverside Ave, suite 170  
Riverside, CA. 92506  
(951) 774-2755

Patient's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell#: \_\_\_\_\_ Home #: \_\_\_\_\_ Email address: \_\_\_\_\_

Please circle **preferred** method of contact: Phone E-mail Patient portal

Patient's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Race** (please circle ): Caucasian/ African American / Asian / Asian Pacific Islander / Multi-racial / American Indian / Other / Decline

**Ethnicity:** Hispanic / Latino: \_\_\_ Non-Hispanic or Latino: \_\_\_ Declined: \_\_\_ **Primary language spoken:** \_\_\_\_\_

**Name of both parents** (if patient is a minor): \_\_\_\_\_ (Mother) \_\_\_\_\_ (Father)

**Name of nearest relative or friend not living with you:** \_\_\_\_\_

Best Contact Tel: \_\_\_\_\_ State of Residence: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Doctor Name:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

**Referred by:** PCP \_\_\_ ENT \_\_\_ Pulm \_\_\_ Derm \_\_\_ Friend \_\_\_ Internet \_\_\_ YELP \_\_\_ Other \_\_\_

## INSURANCE INFORMATION

### PRIMARY INSURANCE:

Name of PRIMARY Insurance Company: \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Circle: PPO or HMO

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

### SECONDARY INSURANCE:

Name of SECONDARY Insurance Company: \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Circle: PPO or HMO

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## PHARMACY INFORMATION

**Name of Regular Pharmacy:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Name of Mail-in Pharmacy:** \_\_\_\_\_ Phone: \_\_\_\_\_

# HIPPA PRIVACY RULE OF PATIENT AUTHORIZATION & PAYMENT AGREEMENT

## Allergy, Sinus, and Asthma Consultants, Inc.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, \_\_\_\_\_ (Patient's Name) understand that as part of my health care, Allergy, Asthma & Sinus Consultants, Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and procedure information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; • A tool for routine health care procedures such as assessing quality and reviewing the competence of health care professionals

If I wish, I can be provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information used and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Allergy, Asthma & Sinus Consultants, Inc.'s notice to prior signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

### PRIVACY RULE OF PATIENT CONSENT AGREEMENT

#### CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (§164.506(a))

I understand that: I have the right to review Allergy, Asthma & Sinus Consultants, Inc.'s notice of information practices prior to signing this consent;

- That Allergy, Asthma & Sinus Consultants, Inc.'s office, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested; • I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Allergy, Asthma & Sinus Consultants, Inc.'s office, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Allergy, Asthma & Sinus Consultants, Inc.'s office has already taken action in reliance thereon.

### HIPPA Consent & Payment Agreement

HIPPA Laws passed by the Federal Government, protect your privacy. We cannot release any information or discuss your care or account with anyone without your specific written permission. The HIPPA Act requires that you include information of whom we may release ANY information to. IF YOU WISH NO ONE TO BE ALLOWED ACCESS PLEASE STATE NO ONE! We will discuss information with no one but the patient or patient's legal guardian. The patient is responsible for all fees, regardless of insurance coverage. I hereby assign to Allergy, Asthma & Sinus Consultants, Inc., all payments for medical services rendered to myself or my dependents.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

I further agree in the event of nonpayment, to bear the cost of collections, and or court costs and reasonable legal fees should this be required. I also authorize the release of any medical information or records needed for my care to other Physicians/Labs or anyone necessary to process this claim. Unless specified above, we may discuss your account and/or records with family members.

**PRINTED NAME** of Patient or Legal Representative \_\_\_\_\_

**SIGNATURE** of Patient or Legal Representative \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Allergy, Sinus and Asthma Consultants, Inc.**

**Amit Patel, M.D. Heena Shah, M.D.**

**Please RELEASE and SEND Medical Information Requested to:**

1282 W. Arrow Highway, Ste 100  
Upland, CA 91786  
(909) 931 – 4034 (909) 931 – 2477 fax

6377 Riverside Ave, Ste 170  
Riverside, CA 92506  
(951) 774 –2755

**MEDICAL RECORDS RELEASE/ REQUEST INFORMATION FROM:**

Name of Medical Group / Clinic / Hospital: \_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip Code: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release and disclose the medical records and information as requested below to **Amit Patel M.D, Heena Shah M.D.** and their staff.

**Release records and information for:**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient Name**

**Medical Record#**

**Date of Birth**

\_\_\_\_\_  
Address City State Zip code

**DURATION:** This authorization is effective immediately and shall remain in effect until \_\_\_\_\_ or one year from the date of signature.

**REVOCATION:** This authorization can be revoked in writing by the patient at any time prior to the release of information.

**RE- DISCLOSURE:** I understand that the requester may not lawfully use or disclose the received information unless a new authorization is requested and signed by me, unless permitted by law.

**SPECIFY** \_\_\_\_\_ General Medical Information from \_\_\_\_\_ to \_\_\_\_\_  
**RECORDS** \_\_\_\_\_ Information regarding specific Treatment \_\_\_\_\_ to \_\_\_\_\_  
**TO BE** \_\_\_\_\_ Imaging (X – rays / CT scan / MRI) Reports  
**RELEASED** \_\_\_\_\_ Pulmonary Function Tests (PFTs) from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ General LAB results from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ Allergy Testing, Lung function, Allergy Care summary from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ OTHER \_\_\_\_\_

I request that the health information released and / or disclosed as specified by this authorization be used for the following purposes only: \_\_\_\_\_

I further **WISH** this information to be shared with **ONLY** \_\_\_\_\_

A copy of this authorization is as valid as an original document.

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Allergy, Sinus and Asthma Consultants, Inc.**  
**Amit Patel, M.D. Heena Shah, M.D.**

**CREDIT CARD AUTHORIZATION FORM**

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

**PATIENT'S NAME:** \_\_\_\_\_

**NAME, AS IT APPEARS ON CREDIT CARD:** \_\_\_\_\_

**BILLING ADDRESS:**  
\_\_\_\_\_  
\_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**AMEX/DISC/MC/VISA CARD # LAST 4 DIGITS** \_\_\_\_\_ *(THE CARD WILL BE ENTERED MANUALLY)*

**EXPIRATION DATE:** \_\_\_\_\_ / \_\_\_\_\_

**VERIFICATION CODE (3 or 4 DIGITS)** \_\_\_\_\_

**Please provide additional family members in our office if this card is to be used for services rendered for them as well.**

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I acknowledge and authorize Allergy, Sinus & Asthma Consultants, Inc to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider.

I acknowledge that my card will be run in the event payment is not received within sixty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

\_\_\_\_\_ **Cardholder Signature**

\_\_\_\_\_ **Date**

# Allergy, Sinus & Asthma Consultants, Inc.

## Acknowledgement of No Show and/or Late arrival

Allergy, Sinus & Asthma Consultants, Inc and its staff are committed to providing quality health treatment to you, our valued patient. Therefore, to keep that commitment, ASAC expects twenty-four (24) hours' notice prior to rescheduling or canceling an appointment. This will allow us to offer that appointment to another patient. Patients who accumulate three (3) No- Shows within one (1) calendar year will result in being dismissed permanently from ASAC.

You will be subject to a No-Show fee of \$25.00.

Additionally, patients who arrive for their appointment after fifteen (15) minutes may result in your appointment being delayed or rescheduled. While we empathize with everyone's situation, please understand our need to standardize our policies.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Interpreter (if applicable)

# Allergy, Sinus & Asthma Consultants, Inc.

Please check, fill in the blanks or circle, as appropriate, as best you can. The physician will go over the questionnaire to obtain more details and clarify any questions.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Other Physicians Seen (specialty, name, tel #): \_\_\_\_\_

**PRESENT OR PAST SYMPTOMS INCLUDE:** (Check the following and write duration of symptoms):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Headaches/Migraines/ Sinus Issue  | <input type="checkbox"/> Loss of Voice/ Hoarseness          | <input type="checkbox"/> Difficulty Breathing or wheezing   |
| <input type="checkbox"/> Tired/Drowsiness/Sleep Apnea      | <input type="checkbox"/> Frequent Tonsillitis               | <input type="checkbox"/> Frequent Bronchitis/Pneumonias     |
| <input type="checkbox"/> Itching/ Watery/ Burning/Red Eyes | <input type="checkbox"/> Yellow or Green Sputum             | <input type="checkbox"/> Snoring or Mouth Breathing         |
| <input type="checkbox"/> Plugging/Itching/Fluid in Ears    | <input type="checkbox"/> Itchy Throat/Sore throats/Drainage | <input type="checkbox"/> Choking, Vomiting, Texture dislike |
| <input type="checkbox"/> Nasal Congestion or Polyps        | <input type="checkbox"/> Choking in the Throat/Mucus        | <input type="checkbox"/> Allergic Reaction to Foods         |
| <input type="checkbox"/> Runny or Itchy Nose               | <input type="checkbox"/> Cough (Dry/Productive)             | <input type="checkbox"/> Itching                            |
| <input type="checkbox"/> Sneezing                          | <input type="checkbox"/> Chest Tightness                    | <input type="checkbox"/> Rash/Skin Problems/Swelling        |

Please explain in detail what your MOST bothersome symptoms are: \_\_\_\_\_

**SYMPTOMS PROVOKED BY:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Dust             | <input type="checkbox"/> Smog/Nearby Traffic | <input type="checkbox"/> Infections          | <input type="checkbox"/> Nighttime/Early AM |
| <input type="checkbox"/> Pets (Cats/Dogs) | <input type="checkbox"/> Physical exertion   | <input type="checkbox"/> Foods/Drugs         | <input type="checkbox"/> Outdoors/Farms     |
| <input type="checkbox"/> Mold             | <input type="checkbox"/> Grass/Trees/Weeds   | <input type="checkbox"/> Work exposures      | <input type="checkbox"/> Air conditioning   |
| <input type="checkbox"/> Tobacco Smoke    | <input type="checkbox"/> Santa Ana Winds     | <input type="checkbox"/> Perfumes/Fragrances | <input type="checkbox"/> Stress             |
| <input type="checkbox"/> Weather Changes  | <input type="checkbox"/> Rain/Humidity       | <input type="checkbox"/> Sulfites            | <input type="checkbox"/> Indoors            |

**SYMPTOMS RELIEVED BY:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> In the Mountains | <input type="checkbox"/> In the Desert   | <input type="checkbox"/> Out of So. California |
| <input type="checkbox"/> On Vacation      | <input type="checkbox"/> On the Weekends | <input type="checkbox"/> During Rain           |
| <input type="checkbox"/> At the Beach     |  | <input type="checkbox"/> Indoor                |

**PAST or CURRENT MEDICATIONS (Brand OR Generic) HAVE INCLUDED (please circle):**

- Antibiotics:** \_\_\_\_\_ # of Lifetime Courses \_\_\_\_\_ Avg # Courses/12 months
- Oral or Injectable Steroids:** \_\_\_\_\_ # of Lifetime Courses \_\_\_\_\_ Avg # Courses/12 months
- Antihistamines/Allergy tablets:** Zyrtec Claritin Allegra Xyzal Benadryl Hydroxyzine Pepcid Zantac Doxepin Singulair Other: \_\_\_\_\_
- Decongestants:** Sudafed Afrin Zyrtec-D Allegra-D Claritin-D Mucinex Other: \_\_\_\_\_
- Nasal Sprays:** Flonase Nasonex Azelastine Nasocort Rhinocort Sensimist Dymista Patanase Ryaltris Ipratropium Other: \_\_\_\_\_
- Topical Treatments:** Hydrocortisone Betamethasone Triamcinolone Clobetasol Mometasone Elidel Protopic Eucrisa Opzelura Fluocinolone Zorvyte VTAMA Anzupgo Other: \_\_\_\_\_
- Inhalers:** Advair Airsupra Arnuity Asmanex Anoro Alvesco Breo Breztri Combivent Dulera Flovent Incruse Pulmicort Qvar Spiriva Stiloto Symbicort Trelegy Utibron Albuterol (Ventolin/Proair/Proventil/Xopenex/Nebulizer)
- Allergy Shots/Immunotherapy:** Duration (months/years) \_\_\_\_\_ Which year? \_\_\_\_\_ Quit \_\_\_\_\_
- Immunologic Therapies:** Xolair Nucala Cinqair Dupilimab Fasenna Tezspire Adbry Nemluvio Exdenseur Ebglyss Rituximab GammaGlobulin Rinvoq Cibinco Other: \_\_\_\_\_
- Other Over the Counter or other Prescription Medications:** \_\_\_\_\_

**PREVIOUS INVESTIGATIONS: (PLEASE BRING COPIES OR HAVE YOUR DOCTOR FAX THE RESULTS)**

- |                                    |  |
|------------------------------------|--|
| Allergy Skin Testing Date _____    | Routine Blood Tests Date _____             |
| Allergy Blood Tests Date _____     | Immunologic Testing Date _____             |
| Pulmonary Function Test Date _____ | Hearing Test Date _____                    |
| Chest X-ray or CT scan Date _____  | Biopsies (skin, esophagus, etc) Date _____ |
| Autoimmune testing Date _____      | Sinus Xray or CT scans Date _____          |

**ALLERGY OR INTOLERANCES TO MEDICINES:** \_\_\_\_\_ No Known Allergies to Medicine

- |            |                |
|------------|----------------|
| Name _____ | Symptoms _____ |
| Name _____ | Symptoms _____ |

**CURRENT MEDICATIONS AND DOSAGES INCLUDE:** Hesitation in Taking Medicines \_\_\_\_\_ List Attached \_\_\_\_\_

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**VACCINATIONS (date last received):** Childhood Vaccines Up-to-date? \_\_\_\_\_

Pneumonia \_\_\_\_\_ Tetanus \_\_\_\_\_ Influenza \_\_\_\_\_ Shingles \_\_\_\_\_ COVID \_\_\_\_\_ RSV \_\_\_\_\_ Meningitis \_\_\_\_\_

**PAST MEDICAL HISTORY (Y/N and CIRCLE or Write Specifics):**

- |   |   |
|---|---|
| <input type="checkbox"/> No significant medical problems  | <input type="checkbox"/> Headaches/migraines or Weight Changes  |
| <input type="checkbox"/> Allergy to Airborne Allergens (Seasonal, Hay fever, All Year)  | <input type="checkbox"/> Mast cell disorders (MCAS, mastocytosis)   |
| <input type="checkbox"/> Anaphylaxis, Angioedema, or Severe Allergic reaction   | <input type="checkbox"/> Hematologic Condition (Deep vein thrombosis, pulmonary)                            |
| <input type="checkbox"/> Breathing Conditions (Asthma, COPD, Sleep Apnea, etc.)   | <input type="checkbox"/> Kidney or Prostate Disease   |
| <input type="checkbox"/> Eczema, Hives or other Skin conditions/Dermatitis  | <input type="checkbox"/> Liver or Spleen Disease  |
| <input type="checkbox"/> Infections (Bronchitis, Ear, Pneumonia, Sinusitis, Skin, Tonsillitis, UTI, Abscesses, etc.)          | <input type="checkbox"/> Malignancy (Cancer, Lymphoma, Leukemia, etc.) & Treatment (Radiation/Chemotherapy) |
| <input type="checkbox"/> Nasal, Ear or Sinus Problems (Deviated septum, polyps, etc)  | <input type="checkbox"/> Neurologic condition (stroke, TIA, etc.)   |
| <input type="checkbox"/> Cardiac Condition (Aneurysm, Heart Attack, High Chol, High Blood Pressure, Pericarditis, POTS, etc)  | <input type="checkbox"/> Orthopedic Conditions  |
| <input type="checkbox"/> Endocrine Condition (Diabetes, Osteoporosis, Thyroid, etc)   | <input type="checkbox"/> Psychiatric Condition (Anxiety, Depression, etc.)                                  |
| <input type="checkbox"/> Eye Condition (Glaucoma, cataracts, conjunctivitis etc.)   | <input type="checkbox"/> Rheumatologic Condition (Lupus, RA, Sjogren's)                                     |
| <input type="checkbox"/> Gastrointestinal Condition (Celiac Disease/Diarrhea, GERD/Reflux, Eosinophilic Esophagitis/Vomiting) | Other _____   |

Previous hospitalizations: REASON \_\_\_\_\_ # of times \_\_\_\_\_ last \_\_\_\_\_  
 Previous ER/Urgent care: REASON \_\_\_\_\_ # of times \_\_\_\_\_ last \_\_\_\_\_  
 Previous ICU admissions: REASON \_\_\_\_\_ # of times \_\_\_\_\_ last \_\_\_\_\_  
 Previous need for ventilator # of times \_\_\_\_\_

**FAMILY HISTORY (Do your parents (m/f), grandparents (gm/gf), siblings (b/s) or children (s/d) have any of the following conditions or please specify any other medical conditions below):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> No History of Allergic Disease | <input type="checkbox"/> Family History is Unknown | <input type="checkbox"/> Lung Condition: Asthma, COPD, Emphysema     |
| <input type="checkbox"/> Hay Fever/Allergies            | <input type="checkbox"/> Immune Deficiency         | <input type="checkbox"/> Cystic Fibrosis or Alpha-1- Antitrypsin Def |
| <input type="checkbox"/> Sinus Disease                  | <input type="checkbox"/> Contact Dermatitis        | <input type="checkbox"/> Pneumonia or Recurrent Infections           |
| <input type="checkbox"/> Skin Condition                 | <input type="checkbox"/> Hives or Swelling         | <input type="checkbox"/> Nasal Polyps                                |
| <input type="checkbox"/> Food Allergy                   | <input type="checkbox"/> Atopic Dermatitis         | <input type="checkbox"/> Autoimmune                                  |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Disease                               |
| <input type="checkbox"/> Thyroid Problems               | <input type="checkbox"/> Glaucoma/Cataracts        | <input type="checkbox"/> Cancer/Leukemia/Lymphoma (_____)            |
- Other Familial Medical Problems \_\_\_\_\_

**PAST SURGICAL HISTORY:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> NO prior surgeries          | <input type="checkbox"/> Tonsillectomy      | <input type="checkbox"/> Heart or Lung Surgery |
| <input type="checkbox"/> Sinus Drainage Procedure    | <input type="checkbox"/> Adenoidectomy      | <input type="checkbox"/> Cancer Surgery        |
| <input type="checkbox"/> Endoscopic Sinus Surgery    | <input type="checkbox"/> Hernia Repair      | <input type="checkbox"/> Gallstone Removal     |
| <input type="checkbox"/> Nasal Polypectomy           | <input type="checkbox"/> Hysterectomy       | <input type="checkbox"/> Eye Surgery           |
| <input type="checkbox"/> Septoplasty/Deviated Septum | <input type="checkbox"/> Appendectomy       | <input type="checkbox"/> Thyroid Removal       |
| <input type="checkbox"/> PE Tubes in Ears            | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Other _____           |

**SOCIAL HISTORY: How Long in Southern California \_\_\_\_\_ Years \_\_\_\_\_ Months**

**Bedroom Environment:** Pets sleep in bedroom \_\_\_\_\_ Dust Control Measures \_\_\_\_\_ Stuffed Animals \_\_\_\_\_ HEPA filter \_\_\_\_\_ Other \_\_\_\_\_  
**Work Environment:** Present Occupation \_\_\_\_\_ Retired (Y/N) \_\_\_\_\_ Disabled, why? \_\_\_\_\_  
**Exposures at work?** \_\_\_\_\_ Previous Occupations \_\_\_\_\_ Years Worked \_\_\_\_\_  
**Infant/Child Environment:** Spends the Day: \_\_\_\_\_ At Home \_\_\_\_\_ Preschool \_\_\_\_\_ Daycare \_\_\_\_\_ Other \_\_\_\_\_  
**Performance in School:** \_\_\_\_\_ Behavior Problems \_\_\_\_\_ # of Days Missed from School/Work, why? \_\_\_\_\_  
**Substance Use:** Alcohol intake, Type and Amount \_\_\_\_\_ **Use of Illicit Drugs, Past or Present** \_\_\_\_\_  
**TOBACCO SMOKE:** PAST OR PRESENT 2<sup>nd</sup> HAND EXPOSURE (Indoor or Outdoor) \_\_\_\_\_ PACKS/DAY \_\_\_\_\_ YEARS OF USE \_\_\_\_\_  
 QUIT, WHEN? \_\_\_\_\_ **HOBBIES:** \_\_\_\_\_

**REVIEW OF SYSTEMS: Any other problems related to other organ systems? (Circle, explain.) Any other explanation?**

- |                  |             |                         |         |        |              |       |              |                    |      |
|------------------|-------------|-------------------------|---------|--------|--------------|-------|--------------|--------------------|------|
| Eye              | Ear         | Heart                   | Lung    | Immune | Muscle/Joint | Nasal | Neurological | Stomach/Intestinal | Skin |
| Thyroid/Diabetes | Psychiatric | Weight Loss/Weight Gain | Fatigue |        |              |       |              |                    |      |