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Allergy & Asthma Institute of SE Michigan

New Patient Registration

COMPREHENSIVE FOOD ALLERGY CLINIC

Please Print

New Patient Name (Last , First , Middle) _____ Nickname _____ Maiden / Former Name _____

☐ Male / ☐ Female _____ Age _____ Date of Birth _____ Social Security Number ☐ Single / ☐ Married / ☐ Divorced / ☐ Widowed

Home Address _____ Apt. # _____

City _____ State _____ Zip _____

Area Code / Home Phone _____ Area Code / Mobile Phone _____ Area Code / Work Phone _____ Ext. _____

Preferred Phone: ☐ Home ☐ Mobile ☐ Work May we leave a message? No ☐ Yes ☐ _____ Email Address

Employer Name _____ Occupation/Title _____ Department _____

Work Address _____ City _____ State _____ Zip _____

Primary Care Physician: Full Name _____ MD or DO? _____ Specialty _____ Physician's Office Area Code & Phone _____

Physician's Mailing Address _____ City _____ State _____ Zip _____ Area Code & Fax Number _____

☆ Preferred Pharmacy: Store Name (for E-Prescribing) _____ Address and/or Store Number _____ City _____ Area Code & Phone Number _____

☆ How did you hear about our office? _____

Emergency Contact: Full Name _____ Relationship to Patient _____ Area Code & Phone Number _____

Primary Insurance _____

Insurance Company Name _____ Area Code & Phone Number (provider services) _____

Claims Address _____ City _____ State _____ Zip _____

Policy ID Number _____ Group # _____ Group Name _____

Policyholder Information _____ Full Name _____ Relationship to Patient _____ Date of Birth _____ Social Security Number _____

Policyholder's Employer: Name _____ Address _____ City _____ State _____ Zip _____ Area Code & Phone Number _____

Secondary Insurance _____

Insurance Company Name _____ Area Code & Phone Number (provider services) _____

Claims Address _____ City _____ State _____ Zip _____

Policy ID Number _____ Group # _____ Group Name _____

Policyholder Information _____ Full Name _____ Relationship to Patient _____ Date of Birth _____ Social Security Number _____

Policyholder's Employer: Name _____ Address _____ City _____ State _____ Zip _____ Area Code & Phone Number _____

Allergy & Asthma Institute of SE Michigan

New Patient Medical & Environmental History

COMPREHENSIVE FOOD ALLERGY CLINIC

Patient Information

Please Print

Name: _____ **Date of Birth** _____ **Date of 1st Visit:** _____

Briefly state what symptoms brought you here_____

Who are your Doctors? Primary Care _____ **Other (name & specialty)** _____

_____

Section 1A: Review of Systems & Medical History

System	Do You Have?			System	Do You Have?		
Constitutional	**Loss of appetite**	☐No	☐Yes	Cardiovascular	**Chest pain**	☐No	☐Yes
	Weight Gain	☐No	☐Yes		**Palpitations**	☐No	☐Yes
	Weight Loss	☐No	☐Yes		**Dizziness or lightheadedness**	☐No	☐Yes
	Fatigue after good sleep	☐No	☐Yes		**Leg swelling**	☐No	☐Yes
	Fever	☐No	☐Yes	Musculoskeletal	**Joint stiffness**	☐No	☐Yes
Endocrine	**Excessive urination**	☐No	☐Yes		**Joint swelling**	☐No	☐Yes
	Excessive thirst	☐No	☐Yes		**Joint pain**	☐No	☐Yes
	Heat intolerance	☐No	☐Yes		**Muscle cramps**	☐No	☐Yes
	Cold intolerance	☐No	☐Yes	Neurology	**Headaches**	☐No	☐Yes
Hematology	**Unusual bleeding**	☐No	☐Yes		**Clumsiness**	☐No	☐Yes
& Lymphatic	**Unusual bruising**	☐No	☐Yes		**Confusion**	☐No	☐Yes
	Swollen glands	☐No	☐Yes		**Numbness**	☐No	☐Yes
Ophthalmology	**Vision Impairment**	☐No	☐Yes		**Paralysis**	☐No	☐Yes
	Loss of vision	☐No	☐Yes		**Seizures**	☐No	☐Yes

Do you have:			**If you answered yes, please provide additional information requested**
Heart Problems?	☐No	☐Yes	**Describe:**
Blood Pressure Problems?	☐No	☐Yes	**Type (high, low, etc) & treatment:**

List other medical problems that you have _____

_____

_____

List all of your current medications (prescription & over the counter)

Medication Name Dose Frequency (how often do you take it?)

_____

_____

_____

_____

_____

_____

Do you have any drug allergies or intolerances? ☐**No** - ☐**Yes**

Medication name or type and the symptom(s) experienced: _____

_____

Section 1B: Review of Systems - HEENT / Upper Respiratory Tract (head, nose, sinus, throat, ears & eyes):

Symptom			If you answered yes, please provide information requested (circle your answers)
Sneezing	☐No	☐Yes	
Itchy nose	☐No	☐Yes	
Congestion (stuffy nose)	☐No	☐Yes	**Which side?** ☐ Left side - ☐ Right side - ☐Both sides
Postnasal drip (drip towards throat)	☐No	☐Yes	
Nasal discharge	☐No	☐Yes	**Is discharge clear?** ☐Yes - ☐No **If no, what color is it?**
Cough from sinus drainage	☐No	☐Yes	
Frontal headaches (forehead, behind eyes)	☐No	☐Yes	
Recurrent sinus infections	☐No	☐Yes	**How many/ year?** ☐ 0 to 4 - ☐more than 4 **Sinus X-ray?** ☐Y - ☐N **Sinus CT?** ☐Y - N☐
Ear plugging/popping/fullness	☐No	☐Yes	
Ear itching	☐No	☐Yes	
Itchy throat	☐No	☐Yes	
Nose bleeds	☐No	☐Yes	**Which side?** ☐Left side - ☐Right side - ☐Both sides
Snoring	☐No	☐Yes	
Bad breath	☐No	☐Yes	
Nasal polyps	☐No	☐Yes	**Side?** ☐Left - ☐Right - ☐Both **Were they removed?** ☐No - ☐Yes **If yes, when?**
Frequent colds	☐No	☐Yes	**How many per year?** ☐1 -5/year - ☐5-10/year
Itchy eyes	☐No	☐Yes	
Watery eyes	☐No	☐Yes	
Eye redness/irritation	☐No	☐Yes	
Dark circles	☐No	☐Yes	
Hearing loss	☐No	☐Yes	☐Left ear - ☐Right ear - ☐Both **Hearing tested?** ☐No - ☐Yes **Result:**

IF you answered YES to any of these symptoms, please Check your answers to the following:

Are any of your symptoms caused or aggravated by: (please CHECK any that apply) ☐dogs - ☐cats - ☐dust (dusting, vacuuming) - ☐strong odors/scents/fragrances - ☐weather change - ☐tobacco smoke - ☐cold air - ☐upper respiratory infections (i.e. colds) - ☐exercise - ☐musty odors - ☐your workplace or school - ☐aspirin or other medications - ☐yard work - ☐pollens - ☐being outdoors - ☐ **NONE OF THESE**

What seasons do you have these symptoms? ☐Year-round - ☐spring - ☐summer - ☐fall - ☐winter

How often do you have the symptoms during these seasons? ☐Every day - _____ times per week - _____ time per month

Do your symptoms interfere with: ☐sleep - ☐exercise/activity - ☐school/work (missed days) - ☐they don't interfere with normal activity

If symptoms interfere with these activities, how often? _____days per week _____days per month

My symptoms are: ☐getting better - ☐ getting worse - ☐staying about the same

What medications or other treatments have you tried? (include prescription & over the counter oral medications, nasal sprays, eye drops, etc)

Name of medication or product	When did you use it?		Did it work?	
	☐In Past	☐Current	☐Yes	☐ No
	☐In Past	☐ Current	☐Yes	☐No
	☐In Past	☐ Current	☐Yes	☐No

For Physician Use Only:

Section 1C: Review of Systems - Pulmonary (Chest & Lungs) Please *CHECK* your answers

Do you have? ☐cough - ☐wheezing - ☐chest tightness - ☐ shortness of breath - ☐throat tightness - ☐**NONE OF THESE (skip to Section 1D)**

IF you answered YES to any of these symptoms, please CHECK your answers to the following:

Are any of your symptoms caused or aggravated by: (please C HECK any that apply) ☐dogs - ☐cats - ☐ dust (dusting, vacuuming) - ☐strong odors/scents/fragrances - ☐weather change - ☐ tobacco smoke - ☐cold air - ☐upper respiratory infections (i.e. colds) - ☐exercise - ☐musty odors - ☐your workplace or school - ☐aspirin or other medications - ☐yard work - ☐pollens - ☐being outdoors - ☐**NONE OF THESE**

What seasons do you have these symptoms? ☐Year-round - ☐spring - ☐summer - ☐fall - ☐winter

How often do you have the symptoms during these seasons? ☐Every day - _____ times per week - _____ time per month

Do your symptoms interfere with: ☐sleep - ☐exercise/activity - ☐school/work (missed days) - ☐they don't interfere with normal activity

If symptoms interfere with these activities, how often? _____days per week _____days per month

My symptoms are: ☐getting better - ☐getting worse - ☐staying about the same

What medications or other treatments have you tried for these symptoms (include prescription & over the counter oral, inhaled and injected medications)

Name of medication or product	When did you use it?		Did it work?	
	☐In Past	☐ Current	☐Yes	☐ No
	☐In Past	☐Current	☐Yes	☐No
	☐In Past	☐Current	☐Yes	☐No

Section 1D: Asthma Please *CIRCLE* your answers

Has a physician ever told you that you have asthma?

No (skip to Section 2) - Yes (please answer these questions and take an "Asthma Control Test" on the next page)

In the past 12 months, how many:				
Courses of oral steroids?	☐ None	☐ 1	☐ 2	☐ ≥3
ER visits due to asthma?	☐ None	☐ 1	☐ 2	☐ ≥3
Hospitalizations due to asthma?	☐ None	☐ 1	☐ 2	☐ ≥3

Have you EVER had an ICU admission for asthma?	☐No	☐Yes	When?
When was your last hospitalization for asthma?			When?
Do you monitor peak flow at home?	☐No	☐Yes	Your Personal Best:

For Physician Use Only:

Asthma Control Test™ (ACT) for **children ages 4 to 11 years old**

Have your child answer these questions: **Score**

1) How is your asthma today?

0 = Very bad ☹ **1** = Bad ☹ **2** = Good ☺ **3** = Very good ☺ _____

2) How much of a problem is your asthma when you run, exercise or play sports?

0 = It's a big problem, I can't do what I want to do **1** = It's a problem and I don't like it **2** = It's a little problem but it's OK **3** = It's not a problem _____

3) Do you cough because of your asthma?

0 = Yes, all of the time **1** = Yes, most of the time **2** = Yes, some of the time **3** = No, none of the time _____

4) Do you wake up during the night because of your asthma?

0 = Yes, all of the time **1** = Yes, most of the time **2** = Yes, some of the time **3** = No, none of the time _____

Parents, please complete the remaining 3 questions on your own:

5) During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5 = Not at all **4 =** 1-3 days **3 =** 4-10 days **2 =** 11-18 days **1 =** 19-24 days **0 =** Everyday _____

6) During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5 = Not at all **4 =** 1-3 days **3 =** 4-10 days **2 =** 11-18 days **1 =** 19-24 days **0 =** Everyday _____

7) During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5 = Not at all **4 =** 1-3 days **3 =** 4-10 days **2 =** 11-18 days **1 =** 19-24 days **0 =** Everyday _____

Your Child's Total Score: _____

Asthma Control Test™ (ACT) for **ages 12 years & older**

1. In **the past 4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or home?

Score

1 All the time **2** Most of the time **3** Some of the time **4** A little of the time **5** None of the time _____

2. During **the past 4 weeks**, how often have you had shortness of breath?

1 More than once a day **2** Once a day **3** 3 to 6 times a week **4** Once or twice a week **5** Not at all _____

3. During **the past 4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1 4 or more nights a week **2** 2 or nights a week **3** once a week **4** Once or twice **5** Not at all _____

4. During **the past 4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

1 3 or more times a day **2** 1 or 2 times a day **3** 2 to 3 times a week **4** Once a week or less **5** Not at all _____

5. How would you rate your **asthma** control during **the past 4 weeks**?

1 Not controlled at all **2** Poorly controlled **3** Somewhat controlled **4** Well controlled **5** Completely controlled _____

Your Total Score: _____

Section 2: Review of Systems - Dermatology (skin) Please *CHECK* your answers

IF you do NOT have skin problems, check here (☐) & skip to Section 3

Do you have? ☐itching - ☐excessively dry & scaly - ☐ irritated red patches - ☐weepy, oozing rash - ☐recurrent skin infections - ☐welts / hives - ☐skin swelling & if yes, where? ☐face - ☐lips - ☐tongue/throat - ☐hands/feet - Other (describe): _____

If welts/hives, when did they start? _____ **If rash**, where is it? _____

Have you seen a Dermatologist? ☐N - ☐Y Who? _____ **What was diagnosis?** _____

What seasons do you have skin symptoms? ☐Year-round - ☐spring - ☐summer - ☐fall - ☐winter

How often do you have the symptoms? ☐Every day - _____ times per week - _____ time per month - Other _____

List everything that aggravates your skin symptoms_____

_____

What medications or other treatments have you tried? (include prescription & over the counter oral medications, creams and ointments)

Name of medication or product	When did you use it?		Did it work?	
	☐ In Past	☐Current	☐ Yes	☐No
	☐In Past	☐Current	☐Yes	☐ No
	☐In Past	☐Current	☐Yes	☐No

Section 3: Food Allergy Please *CHECK* your answers

Do any foods cause tingling/itching/swelling of the lips, tongue or throat? ☐No - skip to section 4 - ☐Yes - What foods?

_____**D**

oes this occur when fruits/vegetables are raw? ☐No - ☐Yes **Raw but peeled?** ☐No - ☐Yes **Well cooked?** ☐No - ☐ Yes **Is there a season that this occurs or when it is more of a problem?** ☐Year around - ☐Spring - ☐Summer - ☐Fall - ☐Winter

If you do NOT have any food allergy problems, check here (☐) and skip to Section 4.

If you have any additional food allergy symptoms or history not listed here, please complete a Food Allergy Patient Questionnaire (separate document).

Section 4: Review of Systems - Gastrointestinal System Please *CHECK* your answers

If you do NOT have stomach or digestive problems, check here (☐) and skip to Section 5. **Do you experience any of the following** (circle all that apply): ☐Heartburn - ☐excessive gas - ☐nausea - ☐vomiting - ☐bloating - ☐diarrhea - ☐constipation **How often do these symptoms occur?** ☐Daily - _____ times a week - _____ times a month - Other (specify): _____

Do any foods or beverages cause or aggravate the symptoms? ☐No - ☐Not sure - ☐Yes (specify)_____

_____

For Physician Use Only: **ROS All systems are otherwise negative: Yes - No**

Section 5: Allergy & Environmental History — Please *CIRCLE* or *CHECK* your answers

Have you ever had:			If yes, please provide the requested additional Information
A reaction to insect sting?	☐No	☐Yes	What type of insect?
If yes: What were your symptoms?	☐No	☐Yes	Swelling/redness only in area of sting - ☐wheezing - ☐anaphylaxis - ☐hives ☐Large area of swelling/redness extending well beyond sting site - ☐difficulty breathing
Was an epinephrine auto-injector prescribed?	☐No	☐Yes	What is the expiration date?

About your home :						
Where do you live?	☐An apartment	☐Townhouse	☐A mobile home	☐Condominium	☐A college dorm	☐A single family home
How long have you lived there?	☐Less than 1 year	☐1 to 5 years	☐5 to 10 Years	☐10 to 20 years	☐More Than 20 years	
How old is the building?	☐Less than 1 year	☐1 to 5 5 years	☐5 to 10 years	☐10 to 20 years	☐More than 20 years	
Type of basement or foundation	☐dry, un-finished basement	☐dry, finished basement	☐un-finished basement with water leak or musty smell	☐finished basement with water leak or musty smell	☐Crawl space	☐Slab
Type of heating & air conditioning in the home	☐Forced air heating	☐Steam heat	☐Hot water/ baseboard heating	☐Air conditioning	☐Humidifier	
Does anyone smoke in the home?	☐No	☐Yes				
Are there any pets in the home?	☐None	☐Cat	☐Dog	☐Hamster or Guinea Pig	☐Bird	☐Reptile
Is pet allowed in the bedroom?	☐No	☐Yes		IF yes, does the pet sleep in the bedroom?	☐No	☐Yes
What type of mattress do you have?	☐Regular mattress	☐Futon	☐Foam mattress	☐Air mattress	☐Waterbed	
Down comforter or feather bed?	☐No	☐Yes				
Pillow Type	☐Feather	☐Non-feather				
Do you have dust mite encasement on the mattress?	☐No	☐Yes		Do you have dust mite encasements on the pillows?	☐No	☐Yes
Is the bedding washed in hot water?	☐No	☐Yes				
How often are the bed linens washed?	☐Weekly	☐Every-other week	Other:	Are there stuffed animals on the bed?	☐No	☐Yes

Section 6: Birth History — Please complete IF the patient is a child less than 6 years old

Pregnancy:

Gestation _____weeks Delivery: ☐Vaginal - ☐C-section ☐Single - Multiple (#-_____) Birth order: _____ Complications?

(describe)_____ Has the child received all scheduled vaccines? ☐Yes - ☐No If no, which vaccines & why not?_____

For Physician Use Only:

Section 7: Past Medical, Social & Family Histories Please *CIRCLE* or *CHECK* your answers

Have you had:			Date(s)	If you answered yes, please provide additional information requested
A flu vaccine?	☐No	☐Yes		
A pneumonia vaccine?	☐No	☐Yes		
T.B. test?	☐No	☐Yes		What was the result? (check one) ☐positive - ☐negative
Previous allergy testing?	☐No	☐Yes		Type: Where & results: ☐Skin - ☐Blood
Hospitalizations?	☐No	☐Yes		Reason:
Surgery?	☐No	☐Yes		Describe:

Social History			If you answered yes, please provide additional information requested
Have you *ever* smoked?	☐No	☐Yes	Amount per day: (Check one) ☐less than ½ pack - ☐½ pack - ☐1 pack - ☐2 or more packs Number of years smoking? _____ Are you currently active? ☐Yes - ☐No Year you quit: _____
Do you drink alcoholic beverages?	☐No	☐Yes	How much? How often? ☐Less than 1 - ☐1 drink - ☐2 or more ☐Per day - ☐Per week - ☐Per month
Do you use marijuana or other recreational drugs?	☐No	☐Yes	How often?

Please check all that apply (even if mild or outgrown):

Family History	Father	Mother	Sibling(s)	Grand-Parent(s)	No Close Relatives With This
Asthma?	☐	☐	☐	☐	☐
Eczema?	☐	☐	☐	☐	☐
Hay Fever?	☐	☐	☐	☐	☐
Food Allergies?	☐	☐	☐	☐	☐
Hives?	☐	☐	☐	☐	☐

Other diseases in the family?			IF yes, what is their relationship to this patient? (i.e. sibling, cousin, etc)
Immune Problems	☐No	☐Yes	
Cystic Fibrosis	☐No	☐Yes	
Emphysema	☐No	☐Yes	

For Physician Use Only:

_____

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