

ALLERGY AND ASTHMA CARE, P.A.

12000 ELM CREEK BLVD. #200

MAPLE GROVE, MN 55369

TEL (763) 420-1010

FAX (763) 420-3710

DATE: _____

LEGAL NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip Code

DATE OF BIRTH:	AGE:	GENDER: M () F ()	MARITAL STATUS S () M () SEP () D ()
HOME PHONE:	WORK PHONE:	OTHER/PAGER/CELL PHONE:	
OCCUPATION:		PATIENT'S EMPLOYER:	
PRIMARY LANGUAGE: (optional)		COUNTRY OF ORIGIN: (optional)	
IS THIS VISIT WORKERS' COMPENSATION RELATED? Y () N () If applicable, please list Claim #			

REFERRED BY: _____ CLINIC NAME: _____

PRIMARY CARE PHYSICIAN: _____ CLINIC NAME: _____

PHARMACY NAME/PHONE # _____

IN CASE OF EMERGENCY, NOTIFY (list name & number):		
PRIMARY INSURANCE COMPANY:	PRIMARY INSURANCE COMPANY ADDRESS:	
CERTIFICATE OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	RELATIONSHIP TO PATIENT:	
POLICY HOLDER EMPLOYER:	POLICY HOLDER DOB:	
SECONDARY INSURANCE COMPANY (N/A)	SECONDARY INSURANCE COMPANY ADDRESS	
CERTIFICATE OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	POLICY HOLDER DOB:	RELATIONSHIP TO PATIENT:

***IF PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

LIST NAME OF RESPONSIBLE PARTY FOR PAYMENT:	LIST RELATIONSHIP TO PATIENT:	
LIST ADDRESS OF RESPONSIBLE PARTY FOR PAYMENT:	LIST PHONE # OF RESPONSIBLE PARTY FOR PAYMENT:	
MOTHER'S NAME:	DOB:	SS #:
HOME ADDRESS:	HOME PHONE:	WORK PHONE:
FATHER'S NAME:	DOB:	SS #:
HOME ADDRESS:	HOME PHONE:	WORK PHONE:

*** PLEASE READ AND SIGN THE BACK OF THIS SHEET AND RETURN WITH YOUR INSURANCE CARD TO THE RECEPTIONIST**

All Current Medicines:

number of mg, tabs,
caps, or inhaler puffs

_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____

PHYSICIAN NOTES

Previous allergy or asthma medications (including OTC):

_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____

Past Medical History:

Birth Weight: _____ Problems at Birth? YES / NO

Surgeries:

(Age or year)

_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____

Hospitalizations (other than surgery):

(Age or year)

_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____

Drug Allergies:

_____	caused	_____	_____
_____	caused	_____	_____

Immunization Adverse Reactions:

_____	caused	_____	_____
_____	caused	_____	_____

Past Allergy History: (use space at right if needed)

YES NO

Previous allergy testing (If 'yes' then answer the questions below)

Testing by Dr. _____ Year _____

Previous allergy shots

Currently on allergy injections every ___ weeks

Do You Have:

YES NO

Cats

Dogs

Birds

Other pets: _____

Feather pillow

Down comforter

Bedroom Carpet

YES NO

Cigarette smoke

Wood burning stove

Damp basement

Mold growth

Room air cleaner

Whole house air cleaner

Workplace: _____

IF YOU ARE CONCERNED ABOUT HIVES OR FOOD ALLERGIES, PLEASE ANSWER THESE QUESTIONS:

HIVES:

PHYSICIAN NOTES

Do you have any other symptoms at the same time?

Wheezing? Y/N

Trouble swallowing? Y/N

Sensation of throat closing? Y/N

Review of Systems

History of low or high thyroid? Y/N

History of hepatitis? Y/N

History of lupus or rheumatoid arthritis? Y/N

Do you work around latex rubber products? Y/N

Do you frequently take Aspirin, Ibuprofen or NSAID's? Y/N

FOOD ALLERGY:

What are your symptoms?

Hives? Y/N

Anaphylaxis? Y/N

Wheezing? Y/N

Throat swelling or trouble swallowing? Y/N

Vomiting or abdominal pain? Y/N

Eczema? Y/N

Other symptoms? Specify _____

Do you know what food causes a reaction? Y/N

Specify: _____

How soon after eating this food do the symptoms appear?

How much of the food do you eat before the reaction occurs?

Have you ever required an ER visit or hospitalization for a food reaction? Y/N _____

Have you ever had testing for food allergies? Y/N