ALLERGY & ASTHMA CENTER

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Lancaster, Pennsylvania 17601

Telephone (717)-393-1365
By Appointment Only

APPOINTMENT DATE: **TIME:**

APPOINTMENT OFFICE:

PHYSICIAN'S NAME:

Dear

PLEASE REVIEW THIS FORM AS SOON AS POSSIBLE

Welcome to our practice. We are dedicated to giving you the best quality care in the fields of allergy, asthma, and immunology. The following information will help you make the most of your time during your visit.

ABOUT YOUR VISIT

At your first consultation, your physician will review your allergy and/or asthma history and do an appropriate physical examination. You will be given the opportunity to discuss with your doctor your own concerns and questions related to allergies and asthma.

Your physician may order skin testing, which will be done during this first visit. Test findings will be discussed with you upon completion. There are often multiple tests; please allow a minimum of **three hours** for your first appointment. We also ask that you arrive **15 minutes early** to check in with our front desk staff. To avoid any delays with your appointment, please bring your **completed** paperwork, insurance card and any copay to your visit.
Please be aware that a convenience fee of 3% will be applied when using credit cards. We also accept checks, cash or ACH.

**Note: A parent/legal guardian must accompany patients under 18 years old and plan to stay for the entire first appointment. For future appointments, an adult other than a parent/legal guardian may accompany a minor child with a signed Consent to Treat form.

MEDICAL INFORMATION

1. Two forms are enclosed **to complete before your initial visit**. Please be sure to bring them with you.

    - **Medical History form**: Please complete as accurately as possible, including all questions in the personal allergy history section. **List all medications and supplements you take, including dosage and frequency of use.** Bring the medication supplements bottles with you.

    - **Insurance Billing form**: Please complete the information necessary for our business office. **Bring your health insurance cards with you.**

2. We need any relevant reports from **laboratory studies, CT scans, or x-rays** (blood work, CTs of sinuses, chest x-rays, etc. – not the films, just the reports.) done in the past six months, if any. **Please obtain copies of the reports**, and either bring them with you, or have them faxed to your appointment office at: (717)393-8540.

ABOUT SKIN TESTING

Should your doctor decide to do skin testing on the day of your appointment, **it is important that you stop taking certain medications EARLY** that interfere with the test results. Although other drugs may interfere, antihistamines are the **ONLY** medicines you should discontinue without prior authorization from your family physician. **DO NOT STOP ANY MEDICATION TAKEN FOR ASTHMA.** Drugs (antihistamines) to be stopped early are listed below. Call if you are uncertain.

Stop the following drugs SEVEN (7) days before your appointment:

Advil PM
Alaway & Zaditor Drops
Astelin
Azelastine
Astepro
Deconamine
Diphenhydramine
Dymista
Elestat Ophthalmic Solution
Livostin Ophthalmic Solution
Optivar Ophthalmic Solution
Pataday
Patanol
Patanase
Periactic (cyproheptadine)
Rynatan
Trinalin or Optimine
Veramyst
All over-the-counter antihistamines, cold medicines, and allergy eye drops, such **as**: Benadryl, Dimetapp, Tavist products, Chlor-Trimeton, Actifed, Tylenol Allergy Sinus, Tylenol PM, Teldrin, PediaCare, Visine Allergy Relief, **etc.**
OTC medications to help you sleep

Stop the following drugs SEVEN (7) days before your appointment:

Allegra/Fexofenadine Products
AlleRx
Alavert
Atarax
Clarinex
Claritin/Loratadine Products
Doxepin
Hydroxyzine
Promethazine
Phenergan
Vistaril
Xyzal/Levocetirizine
Zyrtec/Cetirizine Products

Meclizine**
Antivert**

**If you are unable to STOP these medications, please contact our office to discuss your appointment.

All other medications should be continued unless otherwise advised.

FINANCIAL ARRANGEMENTS

1. Please bring your current medical **insurance card(s)** with you to the visit.
2. Be prepared to **pay your co-pay at the time of your visit**. We participate with most major insurance companies and will accept the assignment.
3. If you are insured through an HMO plan**, it is your responsibility to obtain a referral** from your primary care physician before your visit. Either have your primary care physician fax it to us before your appointment or bring the complete form with you.
4. **It is the patient's responsibility to check with their insurance company as to the benefit coverage for allergy testing, allergy extract and the administration of allergy injections.**

YOUR APPOINTMENT – REMEMBER TO BRING:

- ☐ Completed Medical History form. Your doctor needs this information about you. To avoid any delays with your appointment, please bring your **completed** paperwork.
- ☐ Completed Insurance Billing form.
- ☐ Reports from any pertinent CT scans, chest x-rays, or laboratory studies done in the past six months
- ☐ Health insurance cards.
- ☐ Completed referral form from your primary care physician if you have HMO insurance.
- ☐ Co-pay.
- ☐ Your allergy and asthma questions for your doctor.

****Please Note: In consideration for our patients who have allergic sensitivities to scented products, please do not wear perfume or cologne of any kind, scented hair sprays, etc. when visiting our office.**

APPOINTMENT CANCELLATION POLICY

Many patients need our services. A last minute cancellation deprives someone else of an appointment time. Please notify our New Patient Coordinator of a cancellation or request for an appointment change at least 48 hours (two business days) in advance of your appointment. **If we do not have notification of your cancellation within 2 (two business days) of your appointment, either directly or by voice mail, there will be a $75.00 fee for your absence.**

QUESTIONS?

If you have any questions about your initial visit or any part of the preceding instructions, please feel free to call.

For additional information about the practice, our physicians, and current allergy and asthma topics, please visit our website at **www.allergydoctors.com**.

Sincerely,

New Patient Coordinator

SLH
Revised 4/24/25

Emergency Weather Plan

AAC offices may need to open late or close early due to inclement weather.

In the event that conditions exist that make it hazardous for both our patients and employees we will notify the answering service and put a message on our phone system. AAC will also post any closures or delays at the top of the AAC website at www.allergydoctors.com.

Please Note

In consideration for our patients who have allergic sensitivities to scented products, please do not wear perfume or cologne of any kind, scented hair sprays, scented body spray, scented lotion, etc. when visiting our office.

Forms

Please complete all forms and send back to our office so that we receive them prior to your appointment date. You can either mail them back to us or you can fax them to 717-393-8540.

Patient Name:________________ **Date:**________________
AAC#: ________________ **Patient Signature:** ______________

REVIEW OF SYSTEMS
Do you have any of the following? (ANSWER YES OR NO)
Please provide explanations next to the various items if you experience them. (Examples: when, how often, and how severe?)

General
____significant change in weight □ yes □ no
□ up □ down
____recent fevers or chills □ yes □ no

HEENT
___ Runny nose
___ Sneezing
___ Nasal itching
___ Eye itching
___ Nasal congestion
___ Post Nasal Drip

Skin
____skin rashes (if you are here primarily for an evaluation of a rash we will discuss this in detail)
____recurrent skin infections
____ Hives
How often:

Respiratory
____ Wheeze
____ Shortness of breath
____ Cough
____ Coughs up blood

Gastrointestinal
____acid taste or regurgitation of food
____bloating
____heartburn
____nausea
____vomiting
____ diarrhea
____ rectal bleeding
____ black bowel movements

Cardiovascular
____ankle swelling
____chest pain
____palpitations

Urinary
___blood in the urine
____burning or pain with urination
____loss of urine with coughing
____trouble with urinary flow

Hematologic
____anemia
____bleeding
____bruising easily

Musculoskeletal
___ joint pain

Endocrine
____particularly intolerant to cold □ yes □ no
____particularly intolerant to heat □ yes □ no

Gynecological _______N/A
____abnormal vaginal discharge recently
____change in menstrual cycle
____excessive bleeding

Neurological
____tingling or numbness in an extremity
____unusual weakness-please describe

Psychological
_______excessive anxiety or worry
_______excessive sadness or depression

Patient Label

Name of Referring Doctor/Family Doctor: ______________________________

MEMO TO NEW PATIENTS

AS A HELP TO OUR PROVIDERS, PLEASE WRITE A ONE TO THREE PARAGRAPH SUMMARY AS TO ONSET OF PROBLEM, MEDICATIONS USED, HOW HELPFUL EACH WAS, AND YOUR REMAINING SYMPTOMS.

ALLERGY & ASTHMA CENTER

New Patient Questionnaire

Date: ____________________

Patient's name: ____ Sex: ____ Age: _____ Birthdate: ___________

Parent(s)' name(s) if patient is a minor: ____

Street: ____ City: _______________ State: ______ Zip: ______________

Home telephone: _________________Daytime telephone: ____________________ Cell Phone: __________________

Parent's or responsible party's name: ____

Name of physician who sent you here: ____

Is there another doctor to whom a report should be sent? ____

Names of other family members seen in the practice: ____

I. PERSONAL ALLERGY HISTORY

Patient's MAIN complaint: ____

____

When did the problem begin? ____

SYMPTOMS	Yes	No	?
Trouble with your nose?			
Nasal Itching			
Frequent sneezing			
Clear watery discharge			
White thick discharge			
Colored thick discharge			
Drainage down back of throat			
Periodic			
Constant			
Nasal congestion			
Periodic			
Constant			
Both sides			
One side			
Frequent throat-clearing			
Hoarseness/raspy voice			
Frequent sore throats			
Frequent pressure headaches			
Loss of sense of smell			
Loss of sense of taste			
Sinus infections			
Number per year ________			
Nasal polyps			
Frequent nose bleeds			
Snoring			
Do you use nasal sprays?			
What type? __________			
Trouble with your eyes?			
Redness			
Tearing/Watering			
Swelling			
Itching			
Burning			

SYMPTOMS	Yes	No	?
Trouble with your chest or breathing?			
Wheezing			
Shortness of breath			
Chest tightness			
Cough			
Symptoms noted with: Colds			
Exercise			
Animals			
Other __________			
If cough, describe: Loose			
Dry			
Constant			
Periodic			
Daytime			
Nighttime			
Colored mucus			
Have you seen a physician or been seen in an Emergency room for wheezing?			
Trouble with your skin?			
Rash			
Scaly patches			
Hives			
Swollen areas			
Poison ivy/oak			
Contact rash			
Trouble with your ears?			
Itching			
Popping			
Fluid in ears			
Infection/pain			
Decreased hearing			

What MEDICATIONS you have tried for your symptoms? Did they help? ______________________________

____

____

Circle those things you think contribute to your symptoms or cause them to be WORSE:

Indoors	Weather Change	Hay	Candles
Outdoors	Temperature Change	Barns	Paint Fumes
At Home	Wet Weather	Raking Leaves	Perfumes
At School	Dry Weather	Damp Areas	Smoke
At Work	Cold Day	Dusty Environment	Cleaning products
Morning	Hot Day	Air Conditioning	Newspapers
Afternoon	Hot/Humid Day	Animals	While eating
At Nights	Windy Day	Air Pollution	After eating
Viral Infections	Mowing Lawn	Chemicals	Emotions

Certain drugs (describe): ______________________________

Other: ______________________________

II. MEDICAL HISTORY –

CIRCLE any conditions YOU HAVE (OR HAD IN THE PAST):

☐ None

Asthma	Migraine	Diabetes	Hepatitis
Hay Fever	Pneumonia	Kidney Disease	Tuberculosis
Eczema	Emphysema	Heart Disease	Arthritis
Bronchitis	Acid Reflux	High Blood Pressure	Cancer
Nasal Polyps			Other: __________

HOSPITALIZATIONS (list reason, date, and hospital) ☐ none

1) ______________________________

2) ______________________________

3) ______________________________

LIST ALL MEDICATIONS you are now taking for ANY conditions. List dosages and how each is taken, or bring in your medications. ***Example***: Advair 250/50, one puff twice a day: ______________________________

____

____

____

Are you ALLERGIC to any MEDICATIONS? (Describe reaction): ______________________________

____

Are you ALLERGIC to INSECT STINGS? (Describe reaction): ______________________________

____

Are you ALLERGIC to any FOODS? (Describe reaction): ______________________________

____

III. FAMILY HISTORY

FAMILY MEMBER	AGE
Mother	
Father	
Siblings (name)	
Spouse	
Children (name)	

DISEASES	WHICH RELATIVE(S)?
Sinus Problems	
Hay Fever	
Nasal Allergies	
Asthma	
Emphysema	
Nasal polyps	
Cystic fibrosis	
High Blood Pressure	
Heart Disease	
Diabetes	
Arthritis	
Cancer	

IV. OCCUPATIONAL HISTORY (If patient is your child, state your occupation—it may be influencing your child's condition)

What is your occupation? ______________________________ Employer: ______________________________

Do you feel your occupation has anything to do with your symptoms? Explain: ______________________________

____

How long have you worked for your present employer? ______________________________

IV. PERSONAL ENVIRONMENTAL HISTORY (Please check the correct answer or fill in the blank)

	YES	NO	?
HOME			
Type of home: House			
Apartment			
Dormitory			
Mobile home			
HEATING			
Home heating: Forced air			
Radiant air			
Air filters change every 3 mo.?			
Kerosene Portable or Vented			
Gas			
Oil			
Coal			
Wood			
Vaporizer			
Cool mist Vaporizer			
Steam Vaporizer			
Use: Constant use			
Occasionally used			
Used year-round			
Used when needed			
Do you use a portable air purifier?			
Purifier HEPA filter-type			
Purifier ionizer-type			
# of Air-Purifiers: _______			
Are there damp inside walls?			
Where?			

	YES	NO	?
BEDROOM			
Bedroom has wall-to-wall carpeting			
Pillow - Feather/Down filled			
Not Known			
Pillow covered in dust mite proof cover			
Mattress covered in dust mite proof cover			
Central vacuum cleaner system			
PETS			
Do you have animals in your home?			
Dog: # ( )			
Cat: # ( )			
Rabbit: #( )			
Rodent: #( )			
Ferret: #( )			
Gerbil: #( )			
Hamster: #( )			
Guinea Pig: #( )			
Frog: #( )			
Snake: #( )			
Bird # ( ) Type of bird:			
Have you had pets longer than 3 months			
Pets sleep in the bedroom			
Patient/family member participates in the care of pets (type)			
SMOKING			
Have you ever smoked?			
How long did you smoke?			
How much did you smoke?			

Please circle the months of the year your symptoms are at their worst:

January	February	March	April
May	June	July	August
September	October	November	December

Are your symptoms year-round but worse during these months? Yes / No

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