LITTLE ROCK ALLERGY & ASTHMA CLINIC, P.A.

18 Corporate Hill Drive – Little Rock, Arkansas 72205 – (501)224-1156 – FAX (501)223-2625
www.littlerockallergy.com

PRE-REGISTRATION: NEW PATIENT

PATIENT

☐ Dr. ☐ Miss ☐ Ms ☐ Mrs. ☐ Mr. Patient Name_____
(First) (Middle) (Last) nickname if any

☐ Female ☐ Male Date of Birth_____Age_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

☐ Married ☐ Single ☐ Divorced ☐ Widow/er Social Security Number of Patient _____

Address_____Apt._____Lot_____

City_____State_____Zip_____

Home Phone_____ Work Phone_____ Email_____

Patient's Employer/School_____Occupation_____

Name of Spouse_____Date of Birth_____Social Security Number_____

Spouse's Employer_____Occupation_____Work Phone_____

If patient is a minor: Parents: ☐ Married ☐ Single ☐ Divorced ☐ Widow/er

Father's Name_____ Social Security #_____ Date of Birth_____

Address_____ City/State/Zip_____ Home Phone_____

Father's Employer_____Occupation_____ Work Phone_____

Mother's Name_____ Social Security #_____ Date of Birth_____

Address_____ City/State/Zip_____ Home Phone_____

Mother's Employer_____ Occupation_____ Work Phone_____

Patient lives with MOTHER or FATHER or BOTH (Please circle one)

Patient's Primary Physician_____City/State_____
(if none, type none)

Referring Physician, if different_____City/State_____
(if none, type none)

Who referred you, if different?_____City/State_____

Family Members who are patients at Little Rock Allergy & Asthma Clinic_____

Type of allergy symptoms: Hay Fever/Sinus____Asthma____Hives____Other (please explain)_____

_____

Your appointment (date/time)_____

with Dr. Gene L. France / Dr. Jim M. Ingram / Dr. Deanna N. Ruddell / Dr. Karl V. Sitz / Dr Blake G. Scheer / Dr. Ellen Lu

The undersigned consents to laboratory tests of his/her blood for the hepatitis virus and the human immunodeficiency virus (HIV) if an employee has a potential exposure through contact with the patient.

Signature of Patient or Legal Guardian_____Date_____

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GUARANTOR AND INSURANCE INFORMATION

GUARANTOR OR RESPONSIBLE PARTY

Name_____ Date of Birth_____

Social Security #_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____

Patient's Name (if not the same)_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____ Phone_____
IF NONE, WRITE NONE

Address_____ City/State/Zip_____

Subscriber Name_____ Date of Birth_____

Social Security Number_____ Insurance effective date_____

Relationship to Patient_____

Policy ID Number_____ Group Number_____

SECONDARY INSURANCE INFORMATION

Insurance Company_____ Phone_____
IF NONE, WRITE NONE

Address_____ City/State/Zip_____

Subscriber Name_____ Date of Birth_____

Social Security Number_____ Insurance effective date_____

Relationship to Patient_____

Policy ID Number_____ Group Number_____

ACKNOWLEDGMENT AND AUTHORIZATION

I understand that as the guarantor (patient) I am financially responsible for any balance not covered under the terms and conditions of my health insurance coverage.

I authorize my insurance benefits paid directly to Little Rock Allergy and Asthma Clinic PA 18 Corporate Hill, Little Rock, Arkansas 72205.

I understand if I am unable to keep my scheduled appointment, I am asked to give at least 24 hours notice or possibly be required to pay a fee.

I authorize Little Rock Allergy and Asthma Clinic PA to release any medical or other information to my insurance company when requested.

_____ _____
Signature **Date**

_____ _____
Printed Name **Relationship to patient**

NAME:_____ AGE:_____

Date of Appointment:_____ ID (For Office Use Only):_____

New Patient History

Family Doctor:

Person Completing the form:

- ☐ Patient
- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Guardian
- ☐ Health aide
- ☐ Nurse
- ☐ Other

Referred by:

- ☐ Family Doctor
- ☐ Friend
- ☐ Family member
- ☐ Self
- ☐ Another LRAA patient
- ☐ Other physician
- ☐ Other

What are your main concerns today:

- ☐ congestion
- ☐ runny nose
- ☐ post-nasal drip
- ☐ nasal itch
- ☐ eye itch
- ☐ throat clearing
- ☐ tearing eyes
- ☐ sniffing
- ☐ sinus pain
- ☐ sore throat
- ☐ sneezing
- ☐ cough
- ☐ exercise problems
- ☐ wheezing
- ☐ chest pain
- ☐ shortness of breath
- ☐ asthma
- ☐ headache
- ☐ earache
- ☐ recurrent infections
- ☐ food allergy
- ☐ eczema
- ☐ hives
- ☐ rash
- ☐ stinging insect reactions
- ☐ latex allergy
- ☐ vomiting

Other:

Medication Reaction:

Lung function tests are adjusted based on race for accuracy. Please indicate which item best describes you (the patient):

○ African-American ○ Native American ○ Asian ○ Caucasian ○ Hispanic ○ Other

Medication Name (pills, inhalers, sprays, creams, shots)	Strength/Dose	How Many	How Many Times a Day

Allergy

Are you having (allergy) eye, ear, nose, or throat problems: ○ Yes ○ No

If the above answer is NO please go to Page 4 (4th tab)

How many years have you had symptoms:
- ☐ less than 1
- ☐ 1-5
- ☐ 6-10
- ☐ 11-20
- ☐ over 20

Symptom frequency:
- ☐ daily
- ☐ weekly
- ☐ monthly
- ☐ seasonally
- ☐ rarely
- ☐ none

Please mark the items which best describe your symptoms:

Runny nose:	○ Major problem	○ Less of a Problem	○ Not a Problem
Stuffy nose/Congestion:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sneezing:	○ Major problem	○ Less of a Problem	○ Not a Problem
Nasal itch:	○ Major problem	○ Less of a Problem	○ Not a Problem
Post nasal drip/throat clearing:	○ Major problem	○ Less of a Problem	○ Not a Problem
Hoarseness:	○ Major problem	○ Less of a Problem	○ Not a Problem
Discolored drainage:	○ Major problem	○ Less of a Problem	○ Not a Problem
Facial pressure:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sore throat:	○ Major problem	○ Less of a Problem	○ Not a Problem
Headaches:	○ Major problem	○ Less of a Problem	○ Not a Problem
Snoring:	○ Major problem	○ Less of a Problem	○ Not a Problem
Loss of sense of smell:	○ Major problem	○ Less of a Problem	○ Not a Problem
Nosebleeds:	○ Major problem	○ Less of a Problem	○ Not a Problem
Recurring sinus infections:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sniffing:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sinus Pain:	○ Major problem	○ Less of a Problem	○ Not a Problem
	○ Major problem	○ Less of a Problem	○ Not a Problem

Ears

Recurring ear infections:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Itchy ears:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Ringing in ears:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Popping/Stuffy:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Hearing loss:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Balance problems:	○ Major Problem	○ Less of a Problem	○ Not a Problem

Eyes

Itchy:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Watery:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Red:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Puffy or Dark circles under eyes:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Pain:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Vision Change:	○ Major Problem	○ Less of a Problem	○ Not a Problem

Please indicate if you have had any of the following treatments

If you did have the treatment, please indicate if it was helpful or not

Antihistamines (Claritin,Zyrtec, Allegra, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Decongestants (Tylenol Sinus, Sudafed, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Steroid nasal sprays (Flonase, Rhinocort, Nasonex, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Singulair:	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Non-prescription nasal sprays (Afrin, Neosynephrine, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Antihistamine nasal spray (Astepro, Astelin, Patanase):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Allergy eye drops (Pataday, Bepreve, Optivar, Patanol, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Allergy shots:	○ No	○ Yes - Helpful	○ Yes - Not Helpful
If you had allergy shots, are you still on shots:	○ No	○ Yes - Helpful	○ Yes - Not Helpful

Has Patient Had:

A sinus CT scan in the past year:	○ Yes	○ No
An evaluation by an Ear, Nose, and Throat Specialist:	○ Yes	○ No
Sinus surgery:	○ Yes	○ No
Adenoids removed:	○ Yes	○ No
Tonsils removed:	○ Yes	○ No
Nasal polyps:	○ Yes	○ No
Tubes placed in ears:	○ Yes	○ No
Allergy testing:	○ Yes	○ No

☐ skin test

☐ blood work test

Nasal and/or breathing Symptoms are triggered by:

- ☐ Weather changes
- ☐ Hot humid days
- ☐ household dust
- ☐ outdoor activities
- ☐ exercise
- ☐ infections
- ☐ musty rooms
- ☐ smoke
- ☐ odors/fumes
- ☐ aspirin
- ☐ pets
- ☐ cold air

What are the worst seasons:

- ☐ year round
- ☐ spring
- ☐ summer
- ☐ fall
- ☐ winter

Food Allergy

Have food allergies been a problem: ○ Yes ○ No

Food allergy symtoms:

- ☐ hives/welts
- ☐ mouth/throat itch
- ☐ anaphylactic shock
- ☐ sneezing
- ☐ cough
- ☐ diarrhea
- ☐ wheezing
- ☐ vomiting
- ☐ eczema

Problem foods include:

- ☐ milk
- ☐ wheat
- ☐ fish
- ☐ soy
- ☐ peanut
- ☐ shellfish
- ☐ egg
- ☐ tree nut
- ☐ other

Eczema

Has eczema been a problem: ○ Yes ○ No

Eczema triggers:

- ☐ weather changes
- ☐ food
- ☐ seasons
- ☐ soap/shampoo
- ☐ clothing
- ☐ other
- ☐ none

How long has eczema been a problem:

- ☐ 0-6 months
- ☐ 7-12 months
- ☐ 1-5 years
- ☐ 6-15 years
- ☐ over 15 years

Frequency of symptoms:

- ☐ daily
- ☐ weekly
- ☐ monthly
- ☐ yearly
- ☐ occasionally
- ☐ none

Hives

Have hives been a problem: ○ Yes ○ No

Hives began:
- ☐ recently
- ☐ within the past few months
- ☐ in the past year
- ☐ years ago

Hives are associated with:
- ☐ lip swelling
- ☐ joint swelling
- ☐ bruising
- ☐ eyelid swelling

Hives appear to be triggered by:
- ☐ eating certain foods
- ☐ pain relievers
- ☐ exercise
- ☐ other medication
- ☐ infections
- ☐ cold
- ☐ not sure

Hives occur:
- ☐ daily
- ☐ weekly
- ☐ monthly
- ☐ rarely
- ☐ occasionally
- ☐ none

Hives last for:
- ☐ under 24 hours
- ☐ 1-3 days
- ☐ 1-4 weeks
- ☐ over 4 weeks

Stinging insect reactions

Have stinging insect reactions been a problem: ○ Yes ○ No

Stings causing reactions:
- ☐ ants
- ☐ bees
- ☐ hornets
- ☐ wasps
- ☐ yellow jackets

Reactions:
- ☐ swelling around the sting site only
- ☐ hives/welts
- ☐ trouble breathing
- ☐ passing out
- ☐ other

Do you have epinephrine (Epi-Pen, etc): ○ Yes ○ No

Have you ever been treated in the ER for a sting reaction: ○ Yes ○ No

Have you ever had any of the following: (Past Medical History)

☐ No known Problem

- ☐ migraine headaches
- ☐ high blood pressure
- ☐ epilepsy/seizures
- ☐ hiatal hernia/reflux
- ☐ bipolar disorder
- ☐ thyroid disease
- ☐ kidney disease
- ☐ heart disease
- ☐ osteoporosis
- ☐ fibromyalgia
- ☐ depression
- ☐ ADD/ADHD
- ☐ pneumonia
- ☐ positive TB
- ☐ glaucoma
- ☐ diabetes
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ arthritis
- ☐ cataracts
- ☐ anemia
- ☐ COPD
- ☐ ulcers

Infections:

Current Problems

Cancer:

Other:

Other:

Other:

Birth History - ADULTS SKIP TO IMMUNIZATION

Problems during pregnancy: ○ Yes ○ No

Prematureor term (weeks):
- ☐ under 26
- ☐ 26-30
- ☐ 31-36
- ☐ over 37

Lung disease: ○ Yes ○ No

required ventilation: ○ Yes ○ No

required oxygen: ○ Yes ○ No

Breast fed: ○ less than 4 months ○ 4 months or more

Formula used: ○ Milk-based ○ soy ○ other

Immunizations

Routine childhood immunizations are up to date: ○ Yes ○ No ○ I don't know

Received Pneumovax (Pneumonia vaccine): ○ Yes ○ No ○ I don't know

month / year:

Tetanus in last ten years: ○ Yes ○ No ○ I don't know

Flu shot in the past year: ○ Yes ○ No

month / year:

Tuberculosis status:
- ☐ N/A
- ☐ negative test
- ☐ treated for positive test/diseas

Medication Allergies

Current Allergies

☐ No Known Drug Allergies

Penicillin: ○ Yes

Sulfa: ○ Yes

Codeine: ○ Yes

Morphine: ○ Yes

Aspirin: ○ Yes

Ibuprofen/NSAIDS: ○ Yes

Contrast dye: ○ Yes

Cephalosporins: ○ Yes

Erythromycin: ○ Yes

Other:

Other:

Other:

Other:

Other:

Surgical History

Please indicate if you have had any of the following surgeries

	Year(s)
☐ I have had No surgeries	
☐ C-Section	
☐ Inguinal hernia - Right	
☐ Inguinal hernia - Left	
☐ Hysterectomy - Partial	
☐ Hysterectomy - Complete	
☐ Tubes Tied	
☐ Breast Surgery	
☐ Heart Bypass	
☐ Knee Surgery - Both	
☐ Knee Surgery - Left	
☐ Knee Surgery - Right	
☐ Back Surgery	
☐ Gallbladder Removal	
☐ Appendix Removal	
☐ Cataract Removal	
☐ Colectomy	
☐ Splenectomy	
☐ Tonsillectomy	
☐ Adenoidectomy	
☐ Ear Tubes	
☐ Sinus Surgery	
Other:	
Other:	
Other:	
Other:	
Other:	
Other:	

Family History

Mother's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems	Father's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems	Brother's / Sister's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems	Son's / Daughter's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems
Other:		Other:		Other:		Other:	

Social History

Marital Status: ○ Single ○ Married ○ Divorced/Separated ○ Widow(er)

Smoking Status:
- ○ current every day smoker
- ○ current some day smoker
- ○ former smoker
- ○ never smoker
- ○ unknown if ever smoked
- ○ smoker - current status unknown

Smoking Type: ○ Cigar ○ Cigarettes ○ Pipe

Smoking duration: ○ N/A ○ 1-5 years ○ 6-10 years ○ 11-20 years ○ Over 20 years

Maximum packs per day: ○ 1/2 ○ 1 ○ 1 1/2 ○ 2 or more

Alcohol: ○ Never ○ Rarely ○ Weekly ○ Daily

Do you primarily work: ○ Indoors ○ Outdoors

Occupation:

Other:

Pediatric Patients

Child attends: ○ Daycare ○ Preschool ○ School ○ Home school ○ None

Does child have any brothers or sisters: ○ Yes ○ No

Other:

Environmental History

Housing: ○ House ○ Apartment/Condo ○ Mobile home/Manufactured home

Foundation:
- ☐ Basement
- ☐ Crawlspace
- ☐ Slab

Air Conditioning:
- ☐ None
- ☐ Window Units
- ☐ Central

Other:

Heating:
- ☐ None
- ☐ Wood stove
- ☐ Central Hot air
- ☐ Kerosene
- ☐ Electric Space Heaters

Other:

Have you noticed mold in:
- ☐ None
- ☐ AC vents
- ☐ Bathroom
- ☐ Window frames
- ☐ Walls
- ☐ Basement

Other:

Water damage:
- ☐ None
- ☐ Leaky roof
- ☐ Plumbing problems
- ☐ Musty odors
- ☐ Condensation
- ☐ Water stains

Other:

Pets/animals (Indoor):
- ☐ None
- ☐ Birds
- ☐ Rabbits
- ☐ Cats
- ☐ Hamsters
- ☐ Guinea pigs
- ☐ Dogs
- ☐ Gerbils
- ☐ Other

Other:

Pets/animals (Outdoor):
- ☐ None
- ☐ Chickens
- ☐ Rabbits
- ☐ Cats
- ☐ Horses
- ☐ Cattle
- ☐ Dogs
- ☐ Goats
- ☐ Other

Other:

Pests:
- ☐ None
- ☐ Roaches/Waterbugs
- ☐ Mice/Rats

Other:

Tobacco smoke exposure:
- ☐ None
- ☐ Parents
- ☐ Spouse/Partner
- ☐ Grandparent
- ☐ Caretaker
- ☐ Indoor
- ☐ Outdoor

Other:

Bedroom:
- ☐ Carpet
- ☐ Hardwood
- ☐ Ceiling Fans
- ☐ Humidifier
- ☐ Sleeps in own bed
- ☐ Shares bed

Other:

Bed:
- ☐ Crib mattress
- ☐ Waterbed
- ☐ Allergy mattress cover
- ☐ Stuffed toys
- ☐ Wool blanket
- ☐ Down pillow/comforter
- ☐ Allergy pillow cover
- ☐ Standard mattress

Other:

Outdoor environment:
- ☐ None
- ☐ Construction
- ☐ Timber
- ☐ Chicken houses
- ☐ Farm

Other:

Review of Systems (Current or within the last 12 months)

General:
- ☐ No problems
- ☐ Failure to thrive
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Poor appetite
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight loss
- ☐ See HPI

Heart:
- ☐ No problems
- ☐ Chest pains
- ☐ Congenital heart disease
- ☐ Palpitations
- ☐ Passing out
- ☐ Murmur
- ☐ Difficulty breathing on exertion
- ☐ See HPI

Urinary Tract:
- ☐ No problems
- ☐ Pain on urination
- ☐ Blood in the urine
- ☐ Discharge
- ☐ Urinary frequency
- ☐ Bed wetting
- ☐ Urinary infections
- ☐ Urinary stones
- ☐ See HPI

Hematologic / Lymphatic:
- ☐ No Problem
- ☐ Swollen glands
- ☐ Easy bleeding or bruising
- ☐ See HPI

months)

Skin:
- ☐ No problems
- ☐ Rash
- ☐ Suspicious lesions
- ☐ Dryness
- ☐ Itching
- ☐ Boils
- ☐ Hives
- ☐ Eczema
- ☐ See HPI

Musculoskeletal:
- ☐ No problems
- ☐ Back pain
- ☐ Bone pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ See HPI

Neurologic:
- ☐ No problems
- ☐ Paralysis
- ☐ Weakness
- ☐ Seizures
- ☐ Passing out
- ☐ Tremors
- ☐ Dizziness
- ☐ See HPI

Gastrointestinal:
- ☐ No problems
- ☐ Heartburn/GERD
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Jaundice
- ☐ Bloody stool
- ☐ See HPI

Metabolic:
- ☐ No problems
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive drinking
- ☐ Excessive eating
- ☐ Excessive urination
- ☐ Unexplained weight change
- ☐ See HPI

Psychiatric:
- ☐ No problems
- ☐ Hyperactivity
- ☐ Behavior problems
- ☐ Depression
- ☐ Anxiety
- ☐ See HPI

Asthma

Are you having (Asthma) breathing problems: ○ Yes ○ No

How many years have you had symptoms: ○ less than 1 ○ 1-3 ○ 4-10 ○ 11-30 ○ over 30

Trend of asthma severity: ○ Unchanged ○ Improving ○ Worsening

Steroid (Prelone, Pediapred, Prednisone) bursts in past year: ○ 0 ○ 1-2 ○ 3-5 ○ 6-10 ○ over 10

Please answer yes or no to each of the following

ER visit for asthma in past year: ○ Yes ○ No

Hospitalized for asthma in past year: ○ Yes ○ No

Intensive care unit for asthma: ○ Yes ○ No

Does patient have a peak flow meter: ○ Yes ○ No

Had a chest X-ray in the past year: ○ Yes ○ No

If yes: ○ Normal ○ Abnormal

Please indicate if you have had any of the following treatments

If you did have the treatment, please indicate if it was helpful or not helpful

Oral steroids (prednisone) or steroid shot in past:	○ No	○ Yes - Helpful	○ Yes - Not helpful
Inhaled steroids (Pulmicort, Asmanex, Flovent, etc):	○ No	○ Yes - Helpful	○ Yes - Not helpful
Combination inhalers (Advair, Symbicort, Dulera, etc):	○ No	○ Yes - Helpful	○ Yes - Not helpful
Singulair, Accolate or Zyflo:	○ No	○ Yes - Helpful	○ Yes - Not helpful
Home nebulizer machine:	○ No	○ Yes - Helpful	○ Yes - Not helpful
Spacer device (attachment for inhaler):	○ No	○ Yes - Helpful	○ Yes - Not helpful
Rapid-acting inhalers (Albuterol, Proventil, Proair, Ventolin, etc):	○ No	○ Yes - Helpful	○ Yes - Not helpful

Asthma

Are you being treated for Asthma: ○ Yes ○ No

Patient is 12 years or older

How much of a problem is your asthma when you run, exercise, or play sports:
- ○ It's a big problem - i can't do what I want to
- ○ It's a problem and I don't like it
- ○ It's a little problem but its ok
- ○ It's not a problem

During the past 4 weeks:

Have you missed any work or school due to school: ○ Yes ○ No

How much of the time did your asthma keep you from getting as much done at work, school, or at home:
- ○ All of the time
- ○ Most of the time
- ○ Some of the time
- ○ A little of the time
- ○ None of the time

How often have you had shortness of breath:
- ○ More than once a day
- ○ Once a day
- ○ 3-6 times a week
- ○ Once or twice a week
- ○ Not at all

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:
- ○ 4 or more nights a week
- ○ 2 or 3 nights a week
- ○ Once a week
- ○ Once or twice
- ○ Not at all

How often have you used your rescue inhaler or nebulizer medication (such as albuterol):
- ○ 3 or more times per day
- ○ 1 or 2 times per day
- ○ 2 or 3 times per week
- ○ Once a week or less
- ○ Not at all

How would you rate your asthma control:
- ○ Not controlled at all
- ○ Poorly controlled
- ○ Somewhat controlled
- ○ Well controlled
- ○ Completely controlled

Patient is 4-11 years old (Please have child answer next 4 questions)

How is your asthma today:

- Very bad
- Bad
- Good
- Very good

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

- It's a big problem - I can't do what I want to do
- It's a problem and I don't like it
- It's a little problem but it's OK
- It's not a problem

Do you cough because of your asthma:

- Yes - all of the time
- Yes - most of the time
- Yes - some of the time
- No - none of the time

Do you wake up during the night because of your asthma:

- Yes - all of the time
- Yes - most of the time
- Yes - some of the time
- No - none of the time

During the past 4 weeks, on average, how many days (Answer by parent or care giver)

Did your child have any daytime asthma symptoms:

- None
- 1-3 days/month
- 4-10 days/month
- 11-18 days/month
- 19-24 days/month
- every day

Did your child wheeze during the day because of asthma:

- None
- 1-3 days/month
- 4-10 days/month
- 11-18 days/month
- 19-24 days/month
- every day

Did your child wake up during the night because of asthma:

- None
- 1-3 days/month
- 4-10 days/month
- 11-18 days/month
- 19-24 days/month
- every day

Dear Valued Patient,

If you are unable to keep your appointment, you are asked to provide timely notice of cancellation prior to your appointment time. Unfortunately, in recent years "No show" rates for appointments have increased. If a patient does not keep a scheduled appointment or reschedule prior to 24 hours, it is considered a no show. This creates challenges in scheduling and compromises our ability to provide timely care to all patients needing appointments.

Therefore, effective December 1, 2014, Little Rock Allergy & Asthma Clinic will be implementing a formal policy stating appointments not kept or rescheduled prior to a 24 hour notice will be charged as follows:

- **New Patient Appointments**: $50.00
- **Return Appointments:** $25.00

Patients who fail to pay fee for missed appointments will not be allowed to schedule future appointments until the fee is paid.

Thank you in advance for your consideration and keeping scheduled appointment or rescheduling in a timely matter.

Little Rock Allergy & Asthma Clinic, P.A.
18 Corporate Hill Drive, Suite 110
Little Rock, AR 72205
501-224-1156 • 800-514-4343

DRUGS THAT DO INTERFERE WITH ALLERGY TESTS

ANTIHISTAMINE PREPARATIONS – OMIT 72 HOURS

Accuhist LA
Actifed
Alavert
Allegra (fexofenadine)
Allegra-D
Allerx
Allerx DF
Allerx PE
Antivert
Astelin Nasal Spray
Astepro Nasal Spray
Atarax (hydroxyzine)
Benadryl (diphenhydramine)
Bromfed
Brovex
Chlorpheniramine
Chlor-Trimeton
Clarinex
Clarinex-D
Claritin (loratadine)
Claritin-D
Comhist
Dallergy
Deconamine
Dimetapp
Doxepin
Dramamine
Dura-Vent
Entex
Kronofed
Meclizine
Naldecon
Nalex
Nolahist
Nolamine
Novahistine
Nalex
Nolahist
Nolamine
Novahistine
OTC Antihistamines
Patanase Nasal Spray
Pepcid (famotidine)
Periactin (cyproheptadine)
Phenergan
Rescon
Robitussin
Rondec
Ru-Tuss
Rynatan
Sudal-12
Tagamet (cimetidine)
Tanafed
Tavist
Tussi-12
TussiCaps
Vazobid
Vazotab
Xyzal (levocetirizine)
Zantac (ranitidine)
Zephrex
Zyrtec (cetirizine)
Zyrtec-D

THE FOLLOWING ANTIDEPRESSANTS SHOULD BE OMITTED 72 HOURS BEFORE ALLERGY TESTING (if possible):

Adapin
Elavil (Amitriptyline)
Limbitrol
Nortriptyline
Sinequan
Triavil
Trazodone
Valium (diazepam)

DRUGS THAT DO NOT INTERFERE WITH ALLERGY TESTS

Accolate
Antibiotics
Decadron
Prednisone
Prelone
Singulair
Zyflo

It is <u>not</u> necessary to omit inhalers or nose sprays, except Astelin nasal spray.

Patients with asthma should <u>not</u> stop their asthma medications prior to allergy testing.

REVISED 10/09

LITTLE ROCK ALLERGY & ASTHMA CLINIC, P.A.
Arkadelphia Allergy & Asthma Associates
Bryant Allergy & Asthma Associates
Jacksonville Allergy & Asthma Associates
Pine Bluff Allergy Associates
Russellville Allergy & Asthma Associates
www.littlerockallergy.com

TO OUR NEW PATIENTS:

Thank you for choosing us for your allergy evaluation.

Please complete all paperwork and bring to your appointment.
All paperwork MUST be completed PRIOR to your appointment time.

This appointment is for a complete allergy evaluation, including allergy testing. If for some reason you do not feel that allergy tests are needed, please call and discuss this with one of our nurses at least 48 hours before your appointment.

Discontinue medications containing antihistamine or decongestants 3 days before your appointment. Antihistamines will interfere with allergy testing. If you have any questions about antihistamines and allergy testing, please call our Phone Nurse at least 24 hours before your appointment.

If you have any questions about the enclosed information, please call our office at 501-224-1156 or Toll Free at 800-514-4343.

Thank you,
LITTLE ROCK ALLERGY & ASTHMA CLINIC, P. A.

LRAAC (revised 09/11) du

LITTLE ROCK ALLERGY & ASTHMA CLINIC, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Little Rock Allergy & Asthma Clinic's Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

Patient/Guardian Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____

*If you are **not** the patient, please fill out the following information:*

Patient Name: _____ Patient DOB: _____

Relationship to Patient: _____

Address: _____

Telephone: _____

Please furnish a copy of any conservator/guardianship papers with this form.

I agree and consent to the potential remote monitoring of conversations between me and my physician by a professional transcriptionist/scribe for the purpose of efficiently transcribing the findings of my visit into an electronic medical record. No audio or video recordings will be made.

IF YOU WOULD LIKE SOMEONE ELSE TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION PLEASE FILL OUT INFORMATION BELOW:

I, _____, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION: *(i.e. parent, spouse, significant other, etc.)*

1._____ 3._____

2._____ 4._____