PATRICIA E. JONES, M.D.ALLERGY & ASTHMA CENTER, P.C.

232 NE TUDOR ROAD
LEE'S SUMMIT, MO 64086
816-246-2131

Patient_____ Appointment Date: _____Time: _____

Welcome to our practice. Please read the contents of the enclosed packet carefully and complete the enclosed forms prior to your appointment. If you still have questions please call us at 816-246-2131.

ALLERGY TESTING:

You are scheduled to have allergy skin testing done. This test will help determine what substances you may be allergic to. The basic test contains the most common substances causing allergies including tree, grass, and weed pollen, dust mites, cat and dog dander as well as mold to name a few. This test is comprised of a series of skin pricks on your back. You will have to lay flat on an exam table on your stomach for 15 minutes. Please wear a separate top that can be easily removed for this part of the test. After 15 minutes, the nurse will look at your back and grade the reactions. If you are allergic to a substance, it will look and feel like a mosquito bite. Depending on how large that "mosquito bite" is determines if you are allergic to that substance.

INSTRUCTIONS:

1. All antihistamines must be out of your system for this test to be accurate. Most have to be stopped 3 days prior to the appointment. Claritin needs to be stopped 7 days prior to the appointment. **If you are unsure if a medication you are taking is or contains an antihistamine, please ask us or your pharmacist.**
2. Medications for asthma do not need to be discontinued unless instructed by your physician.
3. Wear a separate top that can be easily removed.
4. Plan on being in the office for approximately 1-2 hours. If you are around any "critters" that you would like to have included in your testing (ex. hamsters, horses) please inform the nurse before testing begins.

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The following is a partial list of medications that contain antihistamines. Many oral products for cold and allergy, as well as sleep aids, anti-nausea and antidepressant medications, frequently contain antihistamines. Any product listed below should be stopped 72 hours before you are scheduled for skin testing unless otherwise noted. If you have any questions regarding whether a medication is an antihistamine, please contact your pharmacy.

(1) Discontinue only if okay with prescribing physician
(2) Discontinue one week before evaluation

Actifed
Alavert
Alka-Seltzer Plus
Allegra
Allegra-D
Allerest
Amitriptyline (1,2)
Antivert
Astelin
Astepro
Atarax
Atrohist
BC Cold Powder
Bayer
Benadryl
Bepreve
Bromfed
Bufferin AF Nite
Cetirizine
Children's Tylenol Allegra-D
Children's Tylenol Cold & Flu
Chlorpheniramine
Chlor-Trimeton
Claritin(2)
Claritin D(2)
Cold Control
Compazine
Comtrex
Clarinex
Contac
Coricidin
Cyroheptadine
Desipramine(1,2)
Dimetapp
Diphenhydramine
Disophrol
Doan's PM
Dorcol Cold
Doxepin (1,2)
Dramamine
Dristin
Drixoral
Dura-Vent/DA
Elavil(1,2)
Fexofenadine
4-Way Cold tabs
Histussin
Hycomine
Hydroxyzine
Imipramine (1,2)
Loratadine (2)
Meclizine
Medi-Flu
Mellaril(1,2)
Miles Nervine Nightime Sleep Aid
Naldecon
Nortiptyline(1,2)
Novahistine
Nyquil
Nytol
Pataday
Patanol Eye Drops
Patanase
Pediacure
Periactin
Phenergan
Ploy-Histine
Prochlorperazine
Prolixine (1)
Robitussin Night Time Cold
Rondec
Rynatan
SemprexD
Sinequan(1,2)
Sinutab
Simply Sleep
Sominex
St.Joseph Night
Stelazine(1)
Sudafed Cold & Allergy
Tavist
Theraflu
Thorazine(1)
Tofranil (1,2)
Triaminic
Trifluoperazine
Tripelennamine
Tussagasic
Tussed
Tussi-12
Tussionex
Tylenol Sinus
Tylenol Cold
Tylenol Cold & Flu
Tylenol PM
Unisom
Vicks
Vistaril
Vivactil (1,2)
Xyzal
Zyrtec
Zyrtec D

***Plain Sudafed may be taken**

Patient Payment Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusions regarding payment for professional medical services. ***Please sign below that you have read and agree to this policy.***

Payment Policy

Payment for service is due in full at the time of service.

We accept cash, check, Visa and MasterCard.

All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.

If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above.

For elective or uncovered services, all co-payments and deductibles are due on the date of service. However, for services estimated to cost more than $200, we will accept half of the balance as the minimum payment. Upon request, a short-term payment arrangement can be considered. **All accounts over 30 days will be charged an interest rate of 1.5% per month (18% annually).**

If your account is over 120 days past due, it will be referred to a collection agency. This is a last resort, done reluctantly, and after we have exhausted efforts for voluntary payment.

Referrals

It is your responsibility to bring any required referral for treatment at, or prior to the time of, your visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible.

Acknowledgement and Authorization

I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility.

_____ _____

Signature Date

_____

Printed Name

PATIENT INFORMATION

Patient Full Name_____

Address_____City_____State_____Zip_____

Home # (___)_____ Work # (___)_____ Cell # (___)_____

Birthdate_____Age_____Sex_____SSN_____

Employer_____Occupation_____

Marital Status_____Spouses Name_____

How did you hear about our office? _____

Name of Physician referred by_____/Phone #_____

Primary Care Physician_____/ Phone #_____

In case of an emergency notify nearest relative not living with you_____

INSURANCE CARRIER EMPLOYMENT INFORMATION

Insurance Carrier___ _____ Member ID#_____

Person Responsible for Payment_____ DOB _____

Employer _____ Phone (___)_____

Work Address_____State_____Zip_____

Occupation_____SSN_____

Please let us know if the insurance has changed from your last visit to update our records. This ensures timely payment for your visit.

I hereby authorize Patricia E. Jones, M.D., Allergy & Asthma Center and it's physicians to treat me/my child. I authorize payment of my insurance benefits to be made to Patricia E. Jones, M.D., Allergy & Asthma Center for any services furnished to me by the physicians in that group. I understand that I am financially responsible for all charges whether paid by insurance or not. (This excludes patients covered by insurance companies with which we have a contract). Should my account become delinquent, I understand that I may be responsible for additional charges if this account is referred to an attorney. I understand that the privacy practices are posted in the office, and a copy is available to me if I request one. I also authorize Patricia E. Jones, M.D., Allergy & Asthma Center to release medical information to insurance companies in order for the insurance companies to determine payment for services rendered to me. This shall serve as a lifetime authorization.

XXXX

SIGNATURE DATE

Patricia E. Jones, M.D. Allergy & Asthma Center

New Patient Questionnaire

232 NE Tudor Road Lee's Summit, MO 64086 Phone: 816-246-2131

Patient Name _____ Date of Birth _____ Today's Date _____

Referring Physician _____ Accompanied Today By _____

In the boxes below – please mark all that apply.

Reason(s) for Visit

- ☐ hay fever/nasal allergies
- ☐ rash/skin allergies
- ☐ food allergy
- ☐ insect allergy
- ☐ eye problems
- ☐ headache/sinus problems
- ☐ ear problems
- ☐ drug reaction
- ☐ cough
- ☐ shortness of breath/asthma
- ☐ chest infections
- ☐ Other: _____

First time problems occured? _____ (date)

When did this specific episode start? ☐ 1 week ago ☐ 2 weeks ago ☐ 3 weeks ago ☐ 4 weeks ago ☐ more than a month ago ☐ unknown

How often does this problem occur? ☐ everyday ☐ once per week ☐ 2 x per week ☐ monthly ☐ several times a year ☐ unpredictable

Which month(s) is it most severe? ☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec ☐ All year

What time of day are the symptoms worse? ☐ morning ☐ noon ☐ afternoon ☐ nighttime ☐ all the time

Are symptoms worse in certain locations? ☐ home ☐ work ☐ outside ☐ indoors ☐ other: _____

Suspected cause of problems? ☐ trees ☐ weeds ☐ grass ☐ mold ☐ dust ☐ perfumes ☐ scents ☐ latex ☐ weather changes ☐ heat ☐ cold ☐ cats ☐ dogs ☐ stress ☐ smoke

☐ other (animals, foods, etc.): _____

How would you grade the degree of your symptoms in the last 4 weeks? ☐ none ☐ mild ☐ moderate ☐ severe

How would grade your degree of symptoms today? ☐ none ☐ mild ☐ moderate ☐ severe

Review of Symptoms I

Please grade each of the following symptoms. (Mark all that apply)

		None	Mild	Moderate	Severe
Allergy/Sinus Symptoms	Dark circles under eyes:	☐	☐	☐	☐
	Itchy/watery eyes:	☐	☐	☐	☐
	Red Eyes:	☐	☐	☐	☐
	Swollen/puffy eyelids:	☐	☐	☐	☐
	Ear infections:	☐	☐	☐	☐
	Ear pain/pressure:	☐	☐	☐	☐
	Ear popping:	☐	☐	☐	☐
	Congestion/blocked nose:	☐	☐	☐	☐
	Decreased sense of smell:	☐	☐	☐	☐
	Nasal/sinus drainage:	☐	☐	☐	☐
	Nose bleeds:	☐	☐	☐	☐
	Runny nose:	☐	☐	☐	☐
	Sinus infection:	☐	☐	☐	☐
	Sinus pressure/pain:	☐	☐	☐	☐
	Sneezing:	☐	☐	☐	☐
	Snoring:	☐	☐	☐	☐
	Snorting:	☐	☐	☐	☐
	Sore throat:	☐	☐	☐	☐
	Hoarseness:	☐	☐	☐	☐
	Post nasal/throat drainage:	☐	☐	☐	☐
	Throat clearing:	☐	☐	☐	☐

		None	Mild	Moderate	Severe
Neurological Symptoms	Dizziness:	☐	☐	☐	☐
	Fatigue/tired:	☐	☐	☐	☐
	Headache:	☐	☐	☐	☐
	Lightheadedness:	☐	☐	☐	☐
	Problems sleeping:	☐	☐	☐	☐
	Poor concentration:	☐	☐	☐	☐
	Sleep apnea:	☐	☐	☐	☐

		None	Mild	Moderate	Severe
Asthma Symptoms	Croup/laryngitis:	☐	☐	☐	☐
	Chest infections:	☐	☐	☐	☐
	Chest tightness:	☐	☐	☐	☐
	Cough:	☐	☐	☐	☐
	Cough productive of mucus:	☐	☐	☐	☐
	Congestion:	☐	☐	☐	☐
	Shortness of breath(SOB):	☐	☐	☐	☐
	SOB with exercise:	☐	☐	☐	☐
	SOB at night:	☐	☐	☐	☐
	Wheezing:	☐	☐	☐	☐

		None	Mild	Moderate	Severe
Skin Symptoms	Dry skin:	☐	☐	☐	☐
	Eczema:	☐	☐	☐	☐
	Hives:	☐	☐	☐	☐
	Itchy skin:	☐	☐	☐	☐
	Rash:	☐	☐	☐	☐
	Skin Swelling:	☐	☐	☐	☐

Gastrointestinal Symptoms		None	Mild	Moderate	Severe
	Constipation:	☐	☐	☐	☐
	Diarrhea:	☐	☐	☐	☐
	Heartburn/Indigestion/Reflux:	☐	☐	☐	☐
	Nausea:	☐	☐	☐	☐
	Vomiting:	☐	☐	☐	☐

Review of Symptoms II

(Mark all that apply)

General:	☐ fever ☐ chills ☐ night sweats ☐ weight loss ☐weight gain
Ears:	☐ drainage ☐ hearing loss ☐ rupture of eardrum
Eyes:	☐ burning ☐ dry
Mouth:	☐ bad breath ☐ gum problems ☐ lip swelling ☐ tongue swelling ☐ pain in teeth ☐ teeth grinding ☐ mouth itching ☐ mouth ulcers
Throat:	☐ difficulty swallowing ☐ swelling ☐ loss of voice
Chest:	☐ chest pain ☐ heaviness/pressure ☐ heart palpitations
Urinary:	☐ excessive urination ☐ excessive thirst ☐ pain/burning with urination ☐ difficulty with urination
Extremities:	☐ swollen joints ☐ painful joints ☐ athletes foot/nail fungus
Neurological:	☐ anxiety ☐ stress ☐ depression ☐ numbness/tingling ☐ tremors ☐ developmental/growth delay ☐ heat or cold intolerance
Other:	

Asthma History A.	1. Have you been previously diagnosed with asthma? Yes No If No – go to Section B 2. What was your age when your asthma began? _____ years 3. During a typical week, how often do asthma attacks awaken you at night? ☐ less than once/week ☐ once or twice/week ☐ 3 x or more/week ☐ more than once/night ☐ never 4. During a typical week (in the past 12 months) how often did you use a Beta Agonist (like Proventil, Albuterol or Ventolin) for asthma? ☐ less than once/week ☐ once or twice/week ☐ 3 x or more/week ☐ daily ☐ more than once daily ☐ never 5. During a typical week, how often were your activities limited by asthma symptoms such as cough, wheezing, or shortness of breath? ☐ less than once/week ☐ once/week ☐ 1 x or more/week ☐ daily ☐ never 6. During the past 12 months, how many times have you gone to the emergency room or had an urgent doctor's visit because of asthma? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more 7. Have you been admitted overnight to a hospital for asthma or breathing disorder in the last 12 months? ☐ Yes ☐ No 8. Do you get chest tightness, wheezing, or shortness of breath within the first 15 minutes of exercise? ☐ Yes ☐ No 9. Do you check peak flows? ☐ Yes ☐ No Best peak flow value _____ 10. Do you have a written Asthma Action Plan? ☐ Yes ☐ No

Please complete entire section.

Asthma History B.	1. Did you ever have recurrent bronchitis, croup, asthma, reactive airway disease during childhood? ☐ Yes ☐ No 2. Have you had sudden severe episodes of coughing, wheezing or shortness of breath? ☐ Yes ☐ No 3. Have you had colds that go "to the chest" and take more than 10 days to get over? ☐ Yes ☐ No 4. Have you had coughing, wheezing, or shortness of breath in certain places when exposed to certain things (e.g. animals, tobacco, smoke, perfumes, etc.)? ☐ Yes ☐ No 5. Have you used medicine to help your breathing? ☐ Yes ☐ No If yes, do symptoms get better with medicine? ☐ Yes ☐ No 6. Do you have coughing, wheezing, or shortness of breath . . . in the morning? ☐ Yes ☐ No at night? ☐ Yes ☐ No with exercise? ☐ Yes ☐ No Other: _____

Sinus History	1. Do you have sinus problems? ☐ Yes ☐ No **If No – Go to Allergy History Section** 2. How many times have you been treated for a sinus infection with an antibiotic in the past year? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more Which antibiotic helped the most? _____ 3. What is the color or your nasal drainage? (Mark all that apply) ☐ clear ☐ brown ☐ white ☐ green ☐ yellow ☐ blood-tinged 4. Have you ever had nasal polyps? ☐ Yes ☐ No 5. Have you ever had an x-ray or CT scan of your sinuses? ☐ Yes ☐ No When was x-ray/scan done? _____ Where was x-ray/scan performed? _____ 6. Have you ever had sinus surgery? ☐ Yes ☐ No When was the sinus surgery? _____ Who was the surgeon? _____ Did the surgery help? ☐ Yes ☐ No ☐ Somewhat 7. Do the sinus problems disturb your sleep enough to cause fatigue, tiredness, or sleepiness during the day? ☐ Yes ☐ No **General Other:**_____

Allergy History	1. Have you ever been tested for allergies? ☐ Yes ☐ No **If NO – Go to question #2** How was testing performed? ☐ skin ☐ blood (rast) How long ago was the test? ☐ less than 1 year ☐ 1-3 years ☐ 4 + years ☐ don't remember What were you allergic to? ☐ trees ☐ weeds ☐ grasses ☐ mold ☐ cats ☐ dogs ☐ foods ☐ insects ☐ latex Did you get allergy shots? ☐ Yes ☐ No How long did you take the shots? ☐ Years ☐ Months ☐ Weeks If yes, were the shots helpful? ☐ Yes ☐ No Who was your doctor? _____ Where can we obtain your allergy test results? _____ Any reaction to insects? ☐ Yes ☐ No

Allergy History Continued	Insect Type (Mark all that apply) ☐ wasp ☐ honey bee ☐ yellow jacket ☐ white faced hornet ☐ yellow hornet ☐ fire ant ☐ mosquito ☐ not sure Type of reaction: _____ 2. Have you ever been prescribed an epi-pen (adrenalin/epinephrine)? ☐ Yes ☐ No If yes, for what purpose? _____ Other: _____

General History	1. In the last 6 months, have you had a cough longer than 6 weeks in a row? ☐ Yes ☐ No 2. In the last 6 months, have you had hoarseness for greater than 6 weeks? ☐ Yes ☐ No 3. In the last 6 months, have you coughed up any blood or bloody sputum? ☐ Yes ☐ No 4. Have you had a chest x-ray in the last year? ☐ Yes ☐ No If yes, where was it performed? _____ When? _____ What were the results? _____ 5. Have you had the pneumonia vaccine shot (Pneumovax)? ☐ Yes ☐ No If yes, when? _____ 6. Do you normally get a flu shot every year? ☐ Yes ☐ No 7. Are your immunizations up to date? ☐ Yes ☐ No 8. During the last year, how many times have you had to take oral or injected steroids for allergies or asthma? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more 9. During the last year, how many days have you missed school or work because of your allergies or asthma? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more 10. During the last year, how many days have your allergies or asthma changed your productivity at work/school due to symptoms? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more 11. How many times have you gone to the emergency room because or your allergies or asthma? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more 12. How many times have you had to stay overnight at the hospital because of allergies or asthma? ☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more 13. Are you pregnant? ☐ Yes ☐ No Date of last menstrual period? _____ Other: _____

Social History	1. Occupation _____ ☐ n/a ☐ student ☐ retired 2. Type of work: _____ 3. Hobbies: _____ 4. Personal tobacco use: ☐ current ☐ past ☐ never How many years have you smoked? _____ How many packs per day? _____ 5. Second hand exposure to tobacco? ☐ Yes ☐ No Who? _____ Where? _____ 6. Do you drink alcohol? ☐ Yes ☐ No 7. Recreational drug use? ☐ Yes ☐ No 8. Do you have any HIV risk factors? ☐ Yes ☐ No ☐ Not sure

(Mark all that apply)

Environmental History

1. Do you have any pets? ☐ Yes ☐ No
   Type of pets? ☐ cats How many? _____
   ☐ dogs How many? _____
   ☐ other How many? _____
   Are they . . . .? ☐ inside ☐ outside ☐ both
   Do they sleep in the bedroom? ☐ Yes ☐ No
2. How old is your home/apartment? _____years
3. Has there been any water leakage or water damage in your home? ☐ Yes ☐ No
4. Do you have visible mold or a musty odor in your home? ☐ Yes ☐ No
5. If patient is a child, does he/she attend daycare? ☐ Yes ☐ No

Family History

What is your ethnic background? ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Are there any family disputes/divorce situations that may make caring for patient more difficult? ☐ Yes ☐ No

(Mark any family members who have experienced any of the listed conditions)

	Father	Mother	Brothers	Sisters	Children	Others
Allergies:	☐	☐	☐	☐	☐	☐
Sinus:	☐	☐	☐	☐	☐	☐
Asthma:	☐	☐	☐	☐	☐	☐
Eczema:	☐	☐	☐	☐	☐	☐
Hay fever:	☐	☐	☐	☐	☐	☐
Hives:	☐	☐	☐	☐	☐	☐
Migraine:	☐	☐	☐	☐	☐	☐
Thyroid Disease:	☐	☐	☐	☐	☐	☐
Emphysema:	☐	☐	☐	☐	☐	☐
Cystic Fibrosis:	☐	☐	☐	☐	☐	☐
Tuberculosis:	☐	☐	☐	☐	☐	☐

Other: _____

Medical History

Please mark all that describe <u>your</u> current or past medical problems.

☐ high blood pressure	☐ reflux	☐ thyroid problems
☐ heart attack	☐ hiatal hernia	☐ kidney problems
☐ stroke	☐ diabetes	☐ chronic infections
☐ glaucoma	☐ emphysema	☐ skin problems
☐ cataracts	☐ lupus/other autoimmune disease	☐ liver problems
☐ depression	☐ gout	☐ bleeding problems
☐ bipolar	☐ arthritis	☐ osteoporosis/osteopenia
☐ ADD/ADHD	☐ fibromyalgia	

Please list all previous hospitalizations/surgeries/prosthetics devices (artificial limbs).

Description	**Year**

Medication History

Please list your prescription, non-prescription, herbal drugs, creams, sprays, pills, liquids, drops, or inhalers.

Current Medications

Medication Name	Dose	Frequency

Medication Or Food Allergies

Do you have any known drug allergies or intolerance to medications? ☐ Yes ☐ No

Medication Allergies:

Medication Name	Type of Reaction	When/Date

Food Allergies:

Food	Type of Reaction	When/Date

Other Notes: _____

Pharmacy Information

Pharmacy Name: _____
Phone Number

Pharmacy Address: _____
Street

_____
City State Zip

Prescription Type: ☐ 90 day mail in ☐ Local ☐ Mail & Local