Augusta Family Allergy and Immunology

Allergy care for your family

www.augustafamilyallergy.com

418 Town Park Blvd., Suite 1A
Evans, GA 30809
Tel: (706) 650-1662 Fax: (706) 550-0074

Patient Information
(Please Print)

Patient's Name:____ Sex: M or F Date of Birth ____/____/____ Age: ______
Last, First, Middle

Home Address: ____ City____________________ State ______ Zip _________

Mailing Address: ____ City____________________ State ______ Zip _________

Home Phone #: ____________________________ Driver's License: ______________________________ SS _______-____-______

Cell Phone #:___________________________Work Phone #:_____________________E-mail address:________________________

Pharmacy: ______________________________________ Phone #: ___________________________

Laboratory used:______________________________

Employer: ____ Patient's Occupation: _______________________________

Employer's Address: ____________________________________ City_________________________ State _______ Zip ________

Emergency Contact: ____ Relationship: ____________

Address: ____________________________________ City________________ State ______ Zip _________ Phone: _____________

Minor's Information

(Complete this section **ONLY** if Patient is under 18 years of age or full time student)

Mother's Name: _____________________________ Driver's License: _____________________________ SS _______-____-______

Employer: ____ Occupation: ______________________________________

Employer's Address: ____________________________________ City_________________________ State _______ Zip ________

Father's Name: ____________________________ Driver's License: _____________________________ SS _______-____-______

Employer's Address: ____________________________________ City_________________________ State _______ Zip ________

Which Parent is the primary insurer?: ☐ Mother ☐ Father Date of Birth of Primary Insurer: ____/_____/______

Is the minor child insured under both, the Mother and Father? ☐ Yes ☐ No

Insurance Information

Primary Insurance Company: __________________________ Secondary Insurance Company: ______________________________

Insured's Name: ___________________________________ Insured's Name: ____

Insured's D.O.B.: __________________________________ Insured's D.O.B. ____

Insured's Policy #: _________________________________ Insured's Policy #: ____

Insured's Group #: _________________________________ Insured's Group #: ____

Effective Date: ____________________________________ Effective Date: ____

I, the undersigned authorize Augusta Family Allergy & Immunology to treat the above named individual, including a minor child. Furthermore, I agree to **ASSIGN THE BENEFITS** to Augusta Family & Immunology, thereby authorizing payment of medical benefits directly to Augusta Allergy & Immunology for services rendered. I agree to be responsible for any co-payment, deductibles, non-covered services, or out of pocket expenses. Additionally, I authorize the release of any medical information necessary to treat the above named individual.

____ ____

Witness Date Signature of Patient or Parent if a Minor Date

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Admission Information

Referred by ☐ Physician/Health care provider ☐ Family/Friend ☐ Insurance company ☐ Yellow Pages

☐ www.augustafamilyallergy.com ☐ Self ☐ Others:___________________

If you checked Family/Friend or Physician/HCP, who should we thank you for? ____

Family/Primary Care Physician's Name:____

Address: ______________________________ City: _________________ State: _______ Zip _________ Phone #: _____________

What do you consider to be your leading Allergy & Immunology problem (s)?

1.____ 3. ____

2. ____ 4. ____

Allergy History (Please check the boxes if you have or had any of the following?

☐ Drug Allergy; specify______________	☐ Hay Fever	☐ Eczema
☐ ________________________________	☐ Sinus Problem	☐ Swelling
☐ Asthma	☐ Food Allergy	☐ Metal Allergy
☐ Frequent infections; specify: ______________	☐ Insect Allergy	☐ Latex Allergy
☐ ______________________________________	☐ Hives	☐ Anaphylaxis

If anyone else in your family has above allergies, please describe: ____

If you have hay fever, asthma or hives which of the following seem to cause or worsen your symptoms;

☐ Dust	☐ Trees in Spring	☐ Mildew
☐ Smoke	☐ Grass in Summer	☐ Exercise
☐ Cats or Dogs	☐ Weeds in Fall	☐ Food; specify _________________
☐ Feather	☐ Weather	☐ Colds/bronchitis
☐ Other _________________________	☐ Rain/dampness	☐ Emotions

Have you ever had allergy skin testing? ☐ Yes ☐ No If yes when; ________________________________

Have you ever had sinus x-ray? ☐ Yes ☐ No If yes when; ________________________________

When was your last chest x-ray? _______________________ It was ☐ normal ☐ abnormal ☐ do not know

Have you ever had a breathing (blowing) test? ☐ Yes ☐ No If yes when; ________________________________

Have you had any antihistamine in the last 3 days? ☐ Yes ☐ No If yes when; ________________________________

What is (are) your other health problem(s)?

1.____ 3. ____

2. ____ 4. ____

Current Medication Regimen

Name	Amount each day	How long?
_________________________________	_________________________________	_________________________________
_________________________________	_________________________________	_________________________________
_________________________________	_________________________________	_________________________________

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System Review

Please check all boxes that apply to you

GENERAL/ENDOCRINE

☐ Poor appetite ☐ Weight Loss ☐ Trouble sleeping ☐ Fatigue
☐ Emotional problems ☐ Missed school/work ☐ Thyroid disease ☐ Diabetes
☐ Others: ______________________________

EYES

☐ Itchy ☐ Tearing ☐ Redness ☐ Blurry
☐ Puffy Eyelids ☐ Dark circles ☐ Excessive discharge ☐ Others _______________

NOSE/SINUSES

☐ Stuffy nose ☐ Itchy nose ☐ Runny nose ☐ Nose bleeds
☐ Sneezing ☐ Snoring ☐ Post-nasal drip ☐ Trouble smelling
☐ Sinus congestion ☐ Headaches

THROAT

☐ Sore throats ☐ Frequent infection ☐ Constant clearing ☐ Voice changes
☐ Bad breath ☐ Tonsils/Adenoid taken out; age ________

EARS

☐ Ear popping ☐ Frequent infection ☐ Ear tubes ☐ Hearing loss
☐ TMJ ☐ Others; ____________________________

RESPIRATORY

☐ Frequent cough ☐ Night cough ☐ Shortness of breath ☐ Chest tightness
☐ Wheezing (asthma) ☐ Colored sputum ☐ Cough up blood ☐ Tuberculosis exposure

CARDIOVASCULAR

☐ Palpitation ☐ Fainting ☐ Angina ☐ High blood pressure
☐ Wake-up short of breath Need 2 or more pillows (otherwise short of breath)
☐ Heart murmur ☐ Ankles swell ☐ Others: ___________________________

GASTROINTESTINAL

☐ Nausea/Vomiting ☐ Difficult to swallow ☐ Indigestion/bloating ☐ Heartburn
☐ Cramps ☐ Diarrhea ☐ Constipation ☐ Blood or mucus in stool
☐ Jaundice/Hepatitis ☐ Hemorrhoids or polyp ☐ Others: _______________

GENITOURINARY

☐ Void frequently ☐ Incontinence ☐ Burning ☐ Bladder/Kidney infections
☐ Blood in urine ☐ Stones ☐ Others: _______________

MUSCULOSKELETAL/NEUROLOGICAL

☐ Muscle weakness ☐ Muscle spasm ☐ Arthritis: specify ______________________
☐ Strokes ☐ Neuritis ☐ Others: ______________________________

HEMATOLOGIC/ONCOLOGICAL

☐ Fever ☐ Anemia ☐ Swollen lymph nodes ☐ Bone pain (constant)
☐ Cancer: specify _______________________

SKIN

☐ Eczema ☐ Dryness ☐ Itching ☐ Hives
☐ Angioedema ☐ Others: ______________________________

FOR FEMALE PATIENTS, PLEASE ANSWER BELOW:

# of pregnancies: ___________________ # of live births: ___________________

Are you pregnant now? ☐ Yes ☐ No

How are your periods? ☐ Normal ☐ Abnormal: specify ______________________ ☐ Menopause

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PAST MEDICAL HISTORY:

Hospitalizations For: ______________________________ When? ______________________________

______________________________ When? ______________________________

______________________________ When? ______________________________

ER visits: For: ______________________________ How Often: ______________________________

Past Medical Problems: please list: ____

____

Past Surgery: please list: ____

____

FOR CHILDREN 0-6 YR OLD, PLEASE ANSWER BELOW:

Birth Weight: ____________ ☐ Breast fed ____________ months ☐ Formula (Cow's milk based) ☐ Formula (Soy-based)

Immunization up to date? ☐ Yes ☐ No

Childhood infections: ☐ Strep throat ☐ Chickenpox ☐ Measles or German Measles ☐ Impetigo

☐ RSV – diagnosed by M.D. ☐ RSV confirmed lab test ☐ Suspected RSV infection

SOCIAL HISTORY:

Martial status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Occupation ______________________________ Anything at work make your symptoms worse? ____________________

Smoking ☐ Current ☐ Past ☐ Secondary

Drug/alcohol user: ☐ Yes ☐ No

Hobbies: ____

FAMILY HISTORY: please check if a blood relative has any of the following

☐ Asthma ☐ Hay Fever ☐ Food allergy ☐ Migraine

☐ Alpha-1 antitrypsin deficiency ☐ Eczema ☐ Hives/angioedema ☐ Diabetes

☐ Cystic Fibrosis ☐ Arthritis ☐ Coronary Heart disease ☐ Hypertension

☐ Lupus or Sarcoidosis ☐ Inflammatory bowel disease. ☐ Cancer; Type______________ ☐ Immune deficiency

ENVIRONMENTAL HISTORY:

☐ House ☐ Apartment How old? ______________________________

Heating: ☐ Central Electric ☐ Gas ☐ Radiator

Air Condition: ☐ Central Air ☐ Window units Humidifier: ☐ Use ☐ Never Use

Basement: ☐ Damp ☐ Musty ☐ Seepage ☐ Flooding

Flooring: Living room____________________ Bedroom ____________________

Bedroom: ☐ Box Spring ☐ Mattress Covers: ☐ Yes ☐ No

Pillow: ☐ Feather ☐ Non Feather Comforter: ☐ Feather ☐ Non Feather

☐ Stuff animals ☐ Toys ☐ Curtains ☐ Blinds

Bedroom pets: ☐ Yes ☐ No

Pets: ☐ Dog ☐ Cat ☐ Hamster ☐ Bird ☐ Other: ____________________

Smokers: ☐ Yes ☐ No Cockroaches: ☐ Have seen ☐ Never see any

I understand the information supplied above is very important to the treatment of my symptoms by Augusta Family Allergy. I have supplied, to the best of my ability, true and accurate information concerning past and present medical history and agree to update Augusta Family Allergy should any changes occur regarding information supplied.

______________________________ ______________________________

Witness Date Signature of Patient or Guardian Date