Dr Fame Allergy & Asthma

1002 Apperson Dr - Salem VA - 24153
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Patient Information

First _____ MI_____ Last_____ __ Pt.ID #_____

Prefers to be called_____ Date of Birth ____/_____/_____ Age ____ Marital Status: _____
Married/ Single/Divorced/Widowed/Other

Address Primary _____ City _____ State_____ Zip _____

Alternate Address _____ City _____ State_____ Zip _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
Home/Cell/ Work Home/Cell/ Work Home/Cell/ Work

Email address _____ Preferred method of contact: Letter Phone call Email Other_____

Sex____ SS # _____Referring Physician _____Primary Care Physician_____
M F

Preferred Language _____ Race: _____Ethnicity: _____
Non Hispanic or Latino/ Hispanic or Latino/ other or Undetermined

Referred by: Physician Self Family/Friend Internet Yellow pages Radio TV Other _____

Occupation_____Employer_____Is this visit related to a work injury? Y N

Current Pharmacy Name and Location _____

Emergency Contact

Name _____Phone # _____Relationship to patient_____

Responsible Party/Guardian/Guarantor Address Same as Patient ☐

Name_____ Address_____ _____ City_____ State ___ __Zip_____

Home# _____ Cell # _____ Business # _____

SS#_____ Patient's Relationship to Guarantor_____ DOB ____/____/____ ____

Sex _____ Occupation_____ Employer _____

Primary Insurance Information Address Same as Patient ☐

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____

Policy Holder Name _____DOB ____/____/_____Relationship to Patient _____ _____

Address_____ ___ City_____ State_____ Zip_____ Phone #_____

SS# _____ Sex_____ Occupation_____ Employer _____

Secondary Insurance Information Address Same as Patient ☐

Name of Ins.Co. _____ID # _____Group# _____Group Name _____

Policy Holder Name _____ DOB ____/____/_____Relationship to Patient_____

Address_____City_____ State. _____Zip_____Phone# _____

SS# _____Sex_____Occupation_____Employer_____

List Any Persons to Whom You Will Allow Access of Your Medical Records

Name/Relationship_____ _____Name/Relationship_____

I hereby authorize the office of Fame Allergy PC to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Fame Allergy PC for services rendered. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

I acknowledge that I have received a copy of . Fame Allergy PC Notice regarding Privacy of Personal Health Information (PHI). I understand that .Fame Allergy PC may request a medication history from my pharmacy as part of my treatment plan, and I hereby give my consent for such requests.

Signature _____Signature_____ Date_____
Patient Responsible Party

Medical History Form

Name:_____ Date of Birth:_____

Past Medical History:
(check any of the following which you have now or have been treated for in the past)

☐ Alcoholism ☐ Anaphylaxis ☐ Cancer ☐ Celiac Disease
☐ Crohn's Disease ☐ COPD ☐ Diabetes ☐ Eczema
☐ Food Allergies ☐ GERD/Reflux ☐ Heart Disease ☐ Hives
☐ Hypertension ☐ Immunodeficiency ☐ Infections, recurring ☐ Immunotherapy, discontinued
☐ Prostate disorder ☐ Renal Calculus ☐ Snoring ☐ Substance abuse
☐ Thyroid problems ☐ Ulcerative colitis ☐ Venom Allergies Other_____
☐ Asthma ☐ Rhinitis (hay fever) _____

Surgical History:

☐ Adenoidectomy ☐ Appendectomy ☐ CABG (heart bypass)
☐ Gallbladder (Cholecystectomy) ☐ Colon Resection ☐ C- section
☐ Deviated Septum ☐ Ear tubes ☐ Hernia Repair
☐ Hip/knee Surgery ☐ Hysterectomy ☐ Organ Transplant
☐ Pacemaker ☐ Sinus Surgery ☐ Tonsillectomy & Adenoidectomy
☐ Tonsillectomy ☐ Thyroid Surgery Other_____

Family History (Immediate family only Mother, Father, Sibling or Children)

	Mother	Father	Sibling	Other
Allergies				
Anaphylaxis				
Angioedema				
Asthma				
Cystic Fibrosis				
Eczema				
Food Allergies				
Heart Disease				
Hives				
Hypertension (high blood pressure)				
Hyperlipidemia (high cholesterol)				
Immunodeficiency				
Infections, recurring				
Venom Allergies				
other _____				

Social History ***(13 years of age and older)***

marital status: ☐ single ☐ divorced/separated ☐ married ☐ widow(er)
smoking status: ☐ current every day smoker ☐ current some day smoker ☐ former smoker
☐ never smoker ☐ unknown if ever smoked
☐ cigarettes _____ packs per day ☐ cigars _____# per day ☐ smokeless/chew _____tins per day
smoking duration: ☐n/a ☐1-5 years ☐6-10 years ☐ 11-20 years ☐over 20 years year started: _____
maximum packs per day: ☐½ ☐1 ☐1 ½ ☐2 or more
passive cigarette exposure: ☐home ☐secondary ☐home ☐other ☐none
readiness to quit: ☐ very ready ☐ somewhat ready ☐ not ready ☐ relapsed ☐ not willing to quit target quit date:_____
occupation:_____ work location: ☐indoors ☐outdoor
caffeine intake (per day) ☐ 0 ☐ 1/2 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+
alcohol intake ☐ never ☐ rarely ☐ weekly ☐ daily ☐ socially
hobbies:_____

Pediatric patients only

attends ☐school ☐daycare (name of school/daycare) _____
does child have siblings ☐yes ☐no if yes, how many _____
child was born ☐premature ☐full term
delivery type ☐vaginal ☐C-section
complicated labor and delivery ☐yes ☐no
prolonged hospitalization as newborn ☐yes ☐no
breast fed ☐yes ☐no
feeding difficulties ☐yes ☐no
ABnormal growth and development ☐yes ☐no
LATE on immunizations ☐yes ☐no
severe infections ☐yes ☐no

Medications - Drug Allergies - Pharmacy

Name:_____ Date of Birth:_____

Current Medications and Supplements

(include milligram and number of times per day)

Medication Name	Strength	Times per Day	Taking This for What Diagnosis?

Allergies to Medications

Name of Medication	Reaction *(hives, throat swelling, other reactions)*

☐ **NO KNOWN DRUG ALLERGIES**

When was your last flu shot?_____

When was your last pneumonia shot?_____

Preferred Pharmacy:

_____(Name)
_____(Street Address)
_____(City, State, ZIP Code)
_____(Telephone Number)
_____(Fax Number)

Chief Complaint - Problem Review - Environment History

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

Reason for today's visit: _____

*Do you **CURRENTLY HAVE ONGOING /RECURRING PROBLEMS** with any of the following:*

General	Nose	Gastrointestinal	Neurologic
☐ no problem	☐ no problem	☐ no problem	☐ no problem
☐ failure to thrive	☐ nasal congestion	☐ heartburn	☐ headaches
☐ fever	☐ runny nose	☐ nausea	☐ weakness
☐ chills	☐ post nasal drip	☐ vomiting	☐ seizures
☐ sweats	☐ nose bleed	☐ diarrhea	☐ passing out
☐ poor appetite	☐ itching	☐ constipation	☐ dizziness
☐ fatigue	☐ sneezing	☐ abdominal pain	
☐ malaise		☐ bloody stool	**Mental Health**
☐ weight loss	**Throat**	☐ jaundice	☐ no problem
	☐ no problem		☐ depression
Eyes	☐ hoarseness	**Musculoskeletal**	☐ anxiety
☐ no problem	☐ difficulty swallowing	☐ no problem	☐ hyperactivity problem
☐ blurring	☐ sore throat	☐ back pain	☐ behavior problems
☐ discharge	☐ oral ulcers	☐ joint pain	
☐ eye pain	☐ throat clearing	☐ joint swelling	**Allergic /Immunologic**
☐ itchy	☐ itching	☐ stiffness	☐ no problem
☐ red			☐ recurring infections
☐ vision loss	**Cardiovascular**	**Skin**	☐ bee sting reaction
☐ watery	☐ no problem	☐ no problem	☐ food reaction
	☐ chest pains	☐ angioedema	☐ latex reaction
Ears	☐ palpitations	☐ dryness	
☐ no problem	☐ passing out	☐ hives	
☐ earache	☐ leg swelling	☐ itching	
☐ ear discharge	☐ shortness of breath lying down	☐ rash	
☐ ringing in ears			
☐ decreased hearing	**Respiratory**		
☐ ears popping	☐ no problem		
☐ room spinning around	☐ cough		
☐ itching	☐ chest tightness		
	☐ coughing up blood		
	☐ daytime sleepiness		
	☐ shortness of breath		
	☐ snoring		
	☐wheezing		

Housing	Foundation	Air Conditioning	Heating
☐ house	☐ basement	☐ none	☐ none
☐ apartment/condo	☐ crawlspace	☐ window units	☐ wood stove
☐ mobile/ manufactured home	☐ slab	☐ central	☐ central hot air
		☐ evaporative cooler	☐ kerosene
			☐ electric space heater
			☐ natural gas

Indoor Mold	Water Damage	Pests	Smoke Exposure	Bedroom
☐ none	☐ none	☐ none	☐ none	☐ carpet
☐ AC vents	☐ leaky roof	☐ roaches	☐ parents	☐ ceiling fan
☐ bathroom	☐ plumbing problems	☐ rodents	☐ spouse/partner	☐ humidifier
☐ window frames	☐ musty odors		☐ grandparent	☐ sleeps in own bed
☐ walls	☐condensation		☐ caretaker	☐ shares bed
☐ basement	☐ water stains		☐ other _____	

Bed	Outdoor Environment	Pets	(how many)
☐ crib mattress	☐ none	☐ none	Dog Inside: _____
☐ standard mattress	☐ cattle	☐ dogs	Dog Outside:_____
☐ water bed	☐ chickens	☐ cats	Cat Inside: _____
☐ down pillow/ comforter	☐ horses	☐ birds	Cat Outside:_____
☐ dust ruffle	☐ goats	☐ hamsters	
☐ stuffed toys	☐ farm	☐ gerbils	
☐ wool blanket		☐ rabbits	
☐ allergy pillow cover		☐ guinea pigs	
☐ allergy mattress cover		☐ other_____	
☐ pets sleeps in bed			