**HEALTHCARE PROVIDER TEAM**

Allergy & ENT Associates Healthcare Provider Team consists of Allergists, Otolaryngologist (ENT), Audiologists, Nurse Practitioners and Physician Assistants. The physician you select for your care is your "Team Leader" and PRIMARY ENT/ ALLERGIST. He or she may work with a Nurse Practitioner or Physician Assistant. From time to time, you may have an office visit with another Group Physician, the Nurse Practitioner, or the Physician Assistant.

Your PRIMARY ENT/ALLERGIST supervises your care, regardless of which type of health care provider delivers care. At any time you can request to see your PRIMARY ENT/ALLERGIST and will be scheduled to be seen as soon as possible. Nurse Practitioners are Advanced Practice Registered Nurses with advanced education and training in the provision of health care. A Nurse Practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. The Physician Assistant also has extensive education and training in the delivery of health care, and can diagnose, treat and monitor your care. A visit with an alternate group physician, the Nurse Practitioner, or the Physician Assistant will expedite prompt treatment of illness and/or efficient follow-up assessment when your primary allergist does not have immediate availability. Please visit our website at www.aentassociates.com for more information about our practice and healthcare team.

**PRIVACY/COMMUNICATIONS**

In addition to telephone calls, we now have the capability to communicate with you via Email and Text Messages. You can review our privacy policy by visiting our website at www.aentassociates.com.

**GRIEVANCES**

If you have any questions, complaints or concerns please contact us at:

Allergy & ENT Associates, ATTN: Executive Director
450 Gears Rd. Ste. 420
Houston, TX. 77067
Tel: (281) 875-8428
Fax: (281) 874-0018

You may also register a complaint with the Texas State Board of Medical Examiners at:

Texas Medical Board, Attention: Investigations
333 Guadalupe, Tower 3, Suite 610,
P.O. Box 2018, MC-263
Austin, Texas 78768-2018
Tel: (800) 201-9353

If you have Medicare and are not satisfied after you have tried to speak directly to people involved in providing your services, or if you are not satisfied the information you received is correct, you may contact the Medicare Ombudsman by mail at:

HHS Office of the Ombudsman
P.O. Box 13247
Austin, Texas 78711-3247
Tel: (877)-787-8999
Fax: (888)-780-8099

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I hereby assign and convey directly to my above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above - named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and /or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/ or insurance reimbursement above, I also assign and/or convey to the above-named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort for insurance concerning medical expenses incurred as a result of the medical services, treatment, therapies, and/or medication I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named health care provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatment, therapies, and/or medication provided by the above-named health care provider, including right to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. I HAVE READ AND FULLY UNDERSTAND THIS ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION.

ALLERGY & ENT ASSOCIATES

REGISTRATION TYPE: _____ NEW PATIENT _____ NEW BENEFITS/INSURANCE

## PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ AGE: _____ SEX: M / F
ADDRESS: _____ EMAIL: _____
SS#: _____ CELL: _____ HOME: _____ WORK: _____
MARITAL STATUS: MARRIED/SINGLE/DIVORCED/WIDOW(ER)
PRIMARY CARE/PEDIATRICIAN: _____ PHONE: _____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

## DISCLOSURE INFORMATION

I AUTHORIZE ALLERGY & ENT ASSOCIATES TO DISCLOSE OR PROVIDE ANY AND ALL PROTECTED PERSONAL HEALTH INFORMATION TO:

NAME: _____ RELATIONSHIP TO PATIENT: _____

## RESPONSIBLE PARTY

☐ SAME AS PATIENT (SKIP TO INSURANCE INFORMATION) RELATIONSHIP TO PATIENT: ____
NAME: _____ DOB: _____ AGE: _____ SEX: M / F
ADDRESS: ☐ SAME AS PATIENT/IF DIFFERENT: _____
EMAIL: _____ PHONE: _____ SS#: _____

## INSURANCE INFORMATION

SUBSCRIBER NAME: _____ DOB: _____
PRIMARY INSURANCE: _____ EMPLOYER: _____
GROUP #: _____ POLICY #: _____

## FINANCIAL STATEMENT

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES NOT COVERED BY MY INSURANCE COMPANY. I UNDERSTAND THAT IF MY INSURANCE COMPANY REQUIRES THAT I HAVE A REFERRAL TO SEE A PROVIDER AT ALLERGY AND ENT ASSOCIATES.IT IS MY RESPONSIBILITY TO OBTAIN THE REFERRAL PRIOR TO MY APPOINTMENT. IF I AM UNABLE TO DO SO, MY APPOINTMENT MAY BE RESCHEDULED OR I MAY BE EXPECTED TO PAY FOR THE CHARGES IN FULL AT THE TIME OF SERVICE. I HEREBY AUTHORIZE PAYMENT TO ANY PHYSICIAN OF ALLERGY & ENT ASSOCIATES WHO HAS TREATED MY DEPENDENTS OR ME FOR MEDICAL SERVICES RENDERED. ALLERGY & ENT ASSOCIATES WILL MAKE EVERY EFFORT TO CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS. HOWEVER, VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT. IF THE INSURANCE COMPANY DENIES PAYMENT OR SERVICES THAT ARE NOT COVERED, THE POLICYHOLDER WILL BECOME FINANCIALLY RESPONSIBLE FOR THOSE SERVICES.

## CANCELLATION FEE

I UNDERSTAND THAT IF I DO NOT GIVE A MINIMUM OF 48 HOUR NOTICE FOR CANCELLATION OF ALLERGY SKIN TESTING APPOINTMENTS, I WILL BE BILLED A $50 CANCELLATION FEE THAT IS NOT COVERED BY THE INSURANCE PLAN. FAILURE TO CANCEL OFFICE VISIT APPOINTMENTS AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT WILL RESULT IN A $30 CHARGE.

## PRIVACY PRACTICES

I HAVE RECEIVED OR WAS OFFERED A COPY FOR REVIEW OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE MY OWN COPY OF THIS DOCUMENT. ALLERGY & ENT ASSOCIATES RESERVES THE RIGHT TO MODIFY THE PRIVACY PRACTICES OUTLINED IN THEIR NOTICE.

## SUMMARY ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION AND NOTICES FOR THE HEALTHCARE PROVIDER TEAM, GRIEVANCES, ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION, PATIENT/INSURANCE INFORMATION FORM, FINANCIAL STATEMENT, CANCELLATION FEES, AND PRIVACY PRACTICES ACKNOWLEDGMENT; I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, UNDERSTAND, AND AGREE, TO THE INFORMATION AS PRESENTED/ PROVIDED. I HAVE REVIEWED THE INFORMATION PROVIDED AND INSURE ITS ACCURACY.

PATIENT NAME (PRINT): _____
SIGNATURE OF PATIENT OR GUARDIAN/PERSONAL REPRESENTATIVE: _____
NAME OF GUARDIAN/PERSONAL REPRESENTATIVE (PRINT): _____
DESCRIPTION OF GUARDIAN PERSONAL REPRESENTATIVE'S AUTHORITY: _____
TODAY'S DATE: _____

ALLERGY & ENT ASSOCIATES

| PATIENT NAME | DATE OF BIRTH | TODAY'S DATE |
|---|---|---|

| REFERRED BY | ACCOMPANIED TODAY BY |
|---|---|
| PRIMARY CARE PHYSICIAN | PHONE |

LIST FAMILY MEMBERS WHO ARE ALSO PATIENTS OF ALLERGY & ENT ASSOCIATES

## ALLERGY HISTORY

| | | |
|---|---|---|
| DO YOU HAVE ALLERGIES/HAY FEVER? | ☐ YES ☐ NO | IF YES, AGE BEGAN _____ |

| | LIST ALL FOODS BELOW: | AGE ONSET: | REACTION: |
|---|---|---|---|
| FOOD ALLERGY/INTOLERANCE: | | | |
| | | | |
| | | | |

| | LIST CONTACT ALLERGENS BELOW: | AGE ONSET: | REACTION: |
|---|---|---|---|
| CONTACT ALLERGIES: | | | |
| | | | |
| | | | |

| | LIST INSECTS BELOW: | AGE ONSET: | REACTION: |
|---|---|---|---|
| INSECT REACTIONS: | | | |
| | | | |
| | | | |

| | |
|---|---|
| HAVE YOU EVER BEEN TESTED FOR ALLERGIES? | ☐ YES ☐ NO |
| HOW WAS TESTING PERFORMED? | ☐ SKIN (PRICKS) ☐ BLOOD (RAST) |
| HOW LONG AGO WAS THE TEST? | |
| WHAT WERE YOU TOLD YOU WERE ALLERGIC TO? | |
| DID YOU RECEIVE IMMUNOTHERAPY? | ☐ NO ☐ YES |
| HAVE YOU EVER BEEN PRESCRIBED AN EPIPEN (ADENALINE/EPINEPHRINE)? | ☐ YES ☐ NO |

## SINUS HISTORY

| | |
|---|---|
| DO YOU HAVE SINUS PROBLEMS? | ☐ YES ☐ NO |
| WHICH ANTIBIOTICS HAVE YOU BEEN ON IN THE LAST YEAR? | |
| NUMBER OF TIMES TREATED FOR SINUS INFECTION WITH AN ANTIBIOTIC IN THE PAST YEAR: | _____ |
| HAVE YOU EVER HAD AN X-RAY OR CT SCAN OF YOUR SINUSES? | ☐ YES ☐ NO |
| IF YES, WHERE WAS THE X-RAY/CT SCAN PERFORMED? | |
| IF YES, WHEN WAS THE X-RAY/CT SCAN PERFORMED? | |

ALLERGY & ENT ASSOCIATES

| RESPIRATORY HISTORY | YES | NO |
|---|---|---|
| BREATHING/ASTHMA SYMPTOMS, INCLUDING COUGHING, WHEEZING, OR SHORTNESS OF BREATH? | ☐ | ☐ |
| RECURRENT BRONCHITIS, CROUP, ASTHMA, REACTIVE AIRWAY DISEASE DURING CHILDHOOD? | ☐ | ☐ |
| HAVE/HAD COLDS THAT GO "TO THE CHEST" AND TAKE MORE THAN 10 DAYS TO GET OVER? | ☐ | ☐ |
| NUMBER OF SYMPTOM-FREE DAYS IN THE LAST 2 WEEKS? | _____ | |
| NUMBER OF EMERGENCY VISITS FOR BREATHING SYMPTOMS IN THE LAST 6 MONTHS? | _____ | |
| NUMBER OF EXACERBATIONS REQUIRING ORAL SYSTEMIC CORTICOSTERIODS IN THE LAST 12 MONTHS? | _____ | |
| WHAT AGE DID YOUR BREATHING SYMPTOMS BEGIN? | _____ | |
| HOW OFTEN DO YOU USE BETA AGONIST INHALER (PROVENTIL, ALBUTEROL, VENTOLIN) PER DAY? | _____ | |

FREQUENCY OF BREATHING SIGNS/SYMPTOMS OVER THE PAST 2-4 WEEKS (NOT JUST ACUTE ATTACKS:

| SYMPTOM TYPE | NUMBER | FREQUENCY PER |
|---|---|---|
| NUMBER OF DAYTIME SYMPTOMS: | | ☐ DAY ☐ MONTH ☐ WEEK |
| NUMBER OF NIGHTTIME SYMPTOMS: | | ☐ DAY ☐ MONTH ☐ WEEK |
| NUMBER OF ACUTE ATTACKS/EXACERBATIONS: | | ☐ DAY ☐ MONTH ☐ WEEK |

| HEARING HISTORY | |
|---|---|
| DO YOU FEEL THAT YOU/YOUR CHILD'S HEARING IS CHANGING? | ☐ YES ☐ NO |
| HAVE YOU/YOUR CHILD EVER BEEN EXPOSED TO LOUD NOISES EITHER RECENTLY OR IN THE PAST YEAR? | ☐ YES ☐ NO |
| HAVE YOU/YOUR CHILD HAD EAR INFECTIONS? | ☐ YES ☐ NO |
| ARE YOU/YOUR CHILD CURRENTLY IN OR PAST USED A HEARING DEVICE? | ☐ YES ☐ NO |

| FOR UNDER 15 YEARS OF AGE ONLY: | |
|---|---|
| DID THEY PASS THEIR NEWBORN HEARING SCREEN? | ☐ YES ☐ NO |
| IF NO, PLEASE CHECK ALL THAT APPLY: | ☐ BIRTH ☐ DELIVERY ☐ NICU ☐ HYPERBILIRUBINEMIA |
| WAS THERE AN ABNORMAL PREGNANCY/DELIVERY? | ☐ YES ☐ NO |
| HISTORY OF DRUG USE OR STD DURING PREGNANCY? | ☐ YES ☐ NO |
| HAS THERE BEEN ANY SPEECH DELAY? | ☐ YES ☐ NO |
| CHILD CURRENTLY RECEIVING SPEECH THERAPY? | ☐ YES ☐ NO |
| OTHER COMMENTS: | |

ALLERGY & ENT ASSOCIATES

| YOUR MEDICAL HISTORY (PROVIDE DATE OF ONSET) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| CONDITION | | ONSET | CONDITION | | ONSET | CONDITION | | ONSET |
| ☐ | ALLERGIES | | ☐ | DEPRESSION | | ☐ | MICROTIA (EAR DEFORMITY) | |
| ☐ | ANEMIA | | ☐ | DIABETES | | ☐ | MULTINODULAR GOITER (THYROID GLAND LUMPS) | |
| ☐ | ANXIETY | | ☐ | HIGH CHOLESTEROL | | ☐ | OBESITY | |
| ☐ | ASTHMA | | ☐ | EMPHYSEMA | | ☐ | OTITIS MEDIA (MIDDLE EAR INFECTION) | |
| ☐ | BIRTH TRAUMA | | ☐ | ENT SYNDROMES | | ☐ | OTOSCLEROSIS (EAR ABNORMAL BONE GROWTH) | |
| ☐ | BLEEDING DISORDER | | ☐ | GERD | | ☐ | SEIZURE DISORDER | |
| ☐ | CANCER | | ☐ | MIGRAINE | | ☐ | SLEEP APNEA | |
| ☐ | CLEFT LIP | | ☐ | HEADACHES | | ☐ | STROKE | |
| ☐ | CLEFT PALATE | | ☐ | HEREDITARY NEPHRITIS (KIDNEY INFLAMMATION) | | ☐ | TINNITUS (EARS RINGING) | |
| ☐ | COPD | | ☐ | HYPERTENSION | | ☐ | VERTIGO (DIZZINESS) | |
| ☐ | CORONARY ARTERY DISEASE | | ☐ | HYPERTHYROIDISM | | | | |
| ☐ | OTHER MEDICAL HISTORY: | | | | | | | |

| YOUR SURGICAL HISTORY (PROVIDE DATE OF SURGERY) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| PROCEDURE | | DATE | PROCEDURE | | DATE | PROCEDURE | | DATE |
| ☐ | ADENOIDECTOMY | | ☐ | CARPAL TUNNEL RELEASE | | ☐ | TONSILLECTOMY | |
| ☐ | ANGIOPLASTY | | ☐ | CHOLECYSTECTOMY | | ☐ | RHINOPLASTY | |
| ☐ | APPENDECTOMY | | ☐ | HERNIA REPAIR | | ☐ | SINOPLASTY | |
| ☐ | BACK SURGERY | | ☐ | HIP REPLACEMENT | | ☐ | SEPTOPLASTY | |
| ☐ | BLOOD TRANSFUSION | | ☐ | KNEE SURGERY | | ☐ | OTHER SURGICAL HISTORY: | |
| ☐ | HEART BYPASS | | ☐ | THYROIDECTOMY | | | | |

ALLERGY & ENT ASSOCIATES

| FAMILY MEDICAL HISTORY | | |
|---|---|---|
| ☐ NO KNOWN FAMILY HISTORY | | |
| I HAVE A FAMILY HISTORY OF: | | CHECK ALL THAT APPLY |
| ☐ | ALLERGIES | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | ASTHMA | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | AUTOIMMUNE DISEASE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | BLOOD DISEASE/DISORDER | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | CANCER: | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| | TYPE(S) OF CANCER: | |
| ☐ | CARDIOVASCULAR DISEASE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | CHRONIC OTITIS MEDIA | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | CLEFT LIP | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | CLEFT LIP & PALATE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | CLEFT PALATE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | CORONARY ARTERY DISEASE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | DEAFNESS | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | DEPRESSION | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | DEVELOPMENTAL DELAY | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | DIABETES | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | ELEVATED LIPIDS | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | GERD | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | HEARING DISORDER | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | HYPERTENSION | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | MIGRAINES | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | OBESITY | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | OTOSCLEROSIS | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | RENAL (KIDNEY) DISEASE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | SEIZURE DISORDER | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | SICKLE CELL DISEASE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | SLEEP APNEA | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | STROKE | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | THYROID DISORDER | ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER ☐ SON ☐ DAUGHTER |
| ☐ | OTHER: | |

ALLERGY & ENT ASSOCIATES

| SOCIAL HISTORY | | | | | |
|---|---|---|---|---|---|
| SMOKING TOBACCO USE: | ☐ NEVER SMOKER ☐ CURRENTLY SMOKE ☐ QUIT | | | | |
| TYPE: | ☐ CIGARETTE ☐ CIGARILLO ☐ PIPE | LAST TIME SMOKED: _____ | | | |
| NON-SMOKING TOBACCO USE: | ☐ NEVER USED ☐ CURRENTLY USE ☐ QUIT | | | | |
| TYPE: | ☐ CHEWING ☐ SMOKELESS ☐ SNUFF | LAST TIME SMOKED: _____ | | | |
| VAPE USE: | ☐ NEVER USED ☐ CURRENTLY USE ☐ QUIT | | | | |
| DEVICE TYPE: | _____ | STRENGTH: _____ | LAST TIME SMOKED: _____ | | |
| DO YOU DRINK ALCOHOL? | ☐ YES ☐ NO ☐ FORMERLY | | | | |
| OCCUPATION: | | STATUS: | ☐ EMPLOYED ☐ UNEMPLOYED | | |

| RESIDENCE | | | | | |
|---|---|---|---|---|---|
| TYPE OF RESIDENCE: | | DUST MITE COVER ON PILLOW? | ☐ YES ☐ NO | | |
| AGE OF BUILDING: | | DUST MITE COVER ON MATTRESS? | ☐ YES ☐ NO | | |
| BEDROOM CONTENTS: | ☐ BLINDS ☐ BOOKS ☐ CARPET ☐ DRAPES ☐ PLANTS ☐ STUFFED ANIMALS | | | | |
| SMOKER IN HOME: | ☐ YES ☐ NO | TYPE OF FLOORS: | ☐ CARPET ☐ WOOD ☐ TILE ☐ AREA RUGS | | |
| RELATIONSHIP TO SMOKER: | | VACUUM TYPE: | ☐ CENTRAL ☐ HEPA ☐ REGULAR | | |
| CENTRAL HEATING/AC: | ☐ YES ☐ NO | DAMP/MOLDY AREAS OF HOUSE: | ☐ YES ☐ NO | | |
| TYPE OF HEAT: | ☐ COAL ☐ ELECTRIC ☐ GAS ☐ SOLAR ☐ WOOD | ALLERGY SYMPTOMS INCREASE AT WORK? | ☐ YES ☐ NO | | |
| TYPE OF BED: | ☐ BOXSPRING ☐ WATERBED ☐ FOAM ☐ CRIB ☐ SOY ☐ ALLERGY COVERED | YARD: | ☐ FARM ☐ OPEN FIELDS ☐ RANCH ☐ OTHER | | |
| DOWN BEDDING: | ☐ YES ☐ NO | ANIMALS AT HOME: | ☐ YES ☐ NO | | |
| DUST MITE COVER ON MATTRESS? | ☐ YES ☐ NO | NUMBER OF ANIMALS: | | | |

| ANIMALS/ENVIRONMENTAL | | | | |
|---|---|---|---|---|
| NUMBER | ANIMAL TYPE | LENGTH OF OWNERSHIP | KEPT INSIDE | KEPT IN BEDROOM |
| | | | ☐ YES ☐ NO | ☐ YES ☐ NO |
| | | | ☐ YES ☐ NO | ☐ YES ☐ NO |
| | | | ☐ YES ☐ NO | ☐ YES ☐ NO |
| | | | ☐ YES ☐ NO | ☐ YES ☐ NO |

| HOBBIES |
|---|
| |

| CHEMICALS AT HOME |
|---|
| |

| CHEMICALS AT WORK |
|---|
| |

ALLERGY & ENT ASSOCIATES

| PLEASE MARK ALL SYMPTOMS YOU ARE CURRENTLY OR HAVE RECENTLY EXPERIENCED: | | | | | | | |
|---|---|---|---|---|---|---|---|
| **CONTITUTIONAL** | | **RESPIRATORY** | | **METABOLIC/ENDOCRINE** | | **NEURO** | |
| ☐ | CHILLS | ☐ | APNEA DURING SLEEP | ☐ | COLD INTOLERANCE | ☐ | DIFFICULTY FALLING ASLEEP |
| ☐ | FATIGUE | ☐ | SHORTNESS OF BREATH | ☐ | HEAT INTOLERANCE | ☐ | DIFFICULTY STAYING ASLEEP |
| ☐ | FEVER | ☐ | SNORING | ☐ | INCREASED THIRST | ☐ | EXCESSIVE DAYTIME SLEEPINESS |
| ☐ | WEIGHT LOSS | ☐ | WHEEZING | ☐ | OTHER: | ☐ | NON-RESTORATIVE SLEEP |
| ☐ | WEIGHT GAIN | ☐ | OTHER: | **HEMATOLOGIC/ LYMPHATIC** | | ☐ | NUMBNESS IN EXTREMITIES |
| ☐ | NIGHT SWEATS | **CARDIO** | | ☐ | EASY BLEEDING | ☐ | SYNCOPE/FAINTING |
| ☐ | OTHER: | ☐ | CHEST PAIN | ☐ | EASY BRUISING | ☐ | TINGLING |
| **HEENT** | | ☐ | HEART MURMUR | ☐ | LYMPHADENOPATHY | ☐ | TREMOR |
| ☐ | BLURRED VISION | ☐ | PALPITATIONS | ☐ | OTHER: | ☐ | WEAKNESS |
| ☐ | CHOKING ON LIQUIDS | ☐ | OTHER: | **ALLERGY/IMMUNOLOGIC** | | ☐ | OTHER: |
| ☐ | CHOKING ON SOLIDS | **GI** | | ☐ | ENVIRONMENTAL ALLERGIES | **EMOTIONAL** | |
| ☐ | DIPLOPIA/DOUBLE VISION | ☐ | ABDOMINAL PAIN | ☐ | FOOD ALLERGIES | ☐ | ANXIETY |
| ☐ | DIZZINESS | ☐ | CONSTIPATION | ☐ | FREQUENT INFECTIONS | ☐ | DEPRESSION |
| ☐ | DROOLING | ☐ | DIARRHEA | ☐ | HAY FEVER | ☐ | HALLUCINATIONS |
| ☐ | DIFFICULTY SWALLOWING | ☐ | HEARTBURN | ☐ | IMMUNO-SUPPRESSION | ☐ | OTHER: |
| ☐ | EAR DRAINAGE | ☐ | VOMITING | ☐ | OTHER: | | |
| ☐ | HEARING LOSS | ☐ | OTHER: | | | | |
| ☐ | HOARSENESS | **URINARY** | | | | | |
| ☐ | MOUTH ULCERS | ☐ | CHANGE IN URINE COLOR | | | | |
| ☐ | OTALGIA/EAR PAIN | ☐ | DYSURIA/PAINFUL URINATION | | | | |
| ☐ | PHARYNGITIS | ☐ | URINARY FREQUENCY | | | | |
| ☐ | TINITIUS/RINGING IN EARS | ☐ | OTHER: | | | | |
| ☐ | VERTIGO/DIZZINESS | | | | | | |
| ☐ | VISUAL CHANGES | | | | | | |
| ☐ | OTHER: | | | | | | |

ALLERGY & ENT ASSOCIATES

# SINO-NASAL OUTCOME QUESTIONNAIRE

PATIENT NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

Below is a standardized assessment used to measure the severity of nasal disorders.

Please rate each item below on how severe it is/has been for the last two weeks on a scale of 0 to 5 ("0" represents a symptom has been ***no problem*** and "5" represents the symptom ***as bad as can be***.)

| SYMPTOM | NO PROBLEM | VERY MILD | MILD OR SLIGHT | MODERATE | SEVERE | AS BAD AS IT CAN BE |
|---|---|---|---|---|---|---|
| NEED TO BLOW NOSE | 0 | 1 | 2 | 3 | 4 | 5 |
| NASAL BLOCKAGE | 0 | 1 | 2 | 3 | 4 | 5 |
| SNEEZING | 0 | 1 | 2 | 3 | 4 | 5 |
| RUNNY NOSE | 0 | 1 | 2 | 3 | 4 | 5 |
| COUGH | 0 | 1 | 2 | 3 | 4 | 5 |
| POST-NASAL DISCHARGE | 0 | 1 | 2 | 3 | 4 | 5 |
| THICK NASAL DISCHARGE | 0 | 1 | 2 | 3 | 4 | 5 |
| EAR FULLNESS | 0 | 1 | 2 | 3 | 4 | 5 |
| DIZZINESS | 0 | 1 | 2 | 3 | 4 | 5 |
| EAR PAIN | 0 | 1 | 2 | 3 | 4 | 5 |
| FACIAL PAIN/PRESSURE | 0 | 1 | 2 | 3 | 4 | 5 |
| DECREASED SENSE OF SMELL/TASTE | 0 | 1 | 2 | 3 | 4 | 5 |
| DIFFICULTY FALLING ASLEEP | 0 | 1 | 2 | 3 | 4 | 5 |
| WAKE UP AT NIGHT | 0 | 1 | 2 | 3 | 4 | 5 |
| LACK OF A GOOD NIGHT'S SLEEP | 0 | 1 | 2 | 3 | 4 | 5 |
| FATIGUE | 0 | 1 | 2 | 3 | 4 | 5 |
| REDUCED PRODUCTIVITY | 0 | 1 | 2 | 3 | 4 | 5 |
| REDUCED CONCENTRATION | 0 | 1 | 2 | 3 | 4 | 5 |
| FRUSTRATED/RESTLESS/ IRRITATABLE | 0 | 1 | 2 | 3 | 4 | 5 |
| SAD | 0 | 1 | 2 | 3 | 4 | 5 |
| EMBARRASSED | 0 | 1 | 2 | 3 | 4 | 5 |
| TOTALS (EACH COLUMN) | | | | | | |
| GRAND SCORE (ALL COLUMNS TOGETHER) | | | | | | |

ALLERGY & ENT ASSOCIATES

| MEDICATION – ALLERGIES | |
|---|---|
| DO YOU HAVE ANY KNOWN DRUG ALLERGIES OR INTOLERANCE(S) TO MEDICATIONS? | ☐ YES ☐ NO |

PLEASE LIST ALL KNOWN DRUG ALLERGIES OR INTOLERANCE(S) BELOW:

| MEDICATION | TYPE OF REACTION | DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATION – HISTORY**

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER, HERBALS, CREAMS, SPRAYS, ETC.

| MEDICATION | DOSE | FREQUENCY | TAKEN FOR: |
|---|---|---|---|
| | | | |
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**PHARMACY INFORMATION**

| | |
|---|---|
| PHARMACY NAME: | |
| PHARMACY ADDRESS: | |
| PHARMACY PHONE NUMBER: | |
| PRESCRIPTION TYPE: | ☐ 90-DAY MAIL-IN ☐ LOCAL ☐ MAIL-IN AND LOCAL |