A&CI ASSOCIATES

180 Fort Couch Rd.
Bethel Park, PA 15241

To Our New Patients:

Welcome to our practice! Please review the following instructions with regard to your initial office visit:

1. **DO NOT take any antihistamines for 72 hours before the appointment.** If you are not certain whether your medication is an antihistamine, please call this office.

2. Antibiotics may be continued if being taken.

3. **All asthma inhalers should be continued.** If you are taking Singulair, Zyflo or Accolate, these should also be continued.

4. **Your initial appointment will usually require 3 to 4 hours.** Please arrive 10 to 15 minutes prior to your appointment time to allow for registration. Please download the history forms from this website and completely fill out prior to your visit. Please bring them with you to the appointment. Failure to do so may result in rescheduling of your appointment.

5. **A parent or legal guardian MUST accompany children under 18 years of age.**

6. Please call 412-833-8811 for the Fort Couch Office or 724-228-7710 for our Washington Office at least 24 hours in advance if you are unable to keep the appointment.

7. Please include the name and address of your family doctor or referring physician. A summary of the allergy evaluation will be mailed to him/her.

8. It is our policy to request payment when services are rendered. Tests and other procedures are additional charges. Please provide your insurance card at the time of the appointment. Any unpaid balance after 120 days will be sent to an outside collection agency.

9. If you have had any recent lab work, chest or sinus x-rays, please obtain a copy of the report(s) for your appointment.

Feel free to contact us should you have any questions about the above instructions or any other aspect of our practice. We look forward to meeting you and providing you with the finest allergy, asthma and immunology care possible.

Enclosures

ALLERGY & CLINICAL IMMUNOLOGY ASSOCIATES

180 Fort Couch Road • Pittsburgh, PA • 15241-1041
FAX: 412 • 833 • 7011
412 • 833 • 8811

1385 Washington Road • Suite 101 • Washington, PA • 15301-9674
FAX: 724 • 228 • 7741
724 • 228 • 7710

Welcome To Our Office

Patient Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: (_____) _____ Birthdate: _____ Age: _____
Occupation: _____ Social Security Number: _____ - _____ - _____
Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Employer's Telephone: (_____) _____

Complete this section only if someone other than the patient is financially responsible. In the case of a child not living with both parents, ***the responsible party is the parent who accompanies the child to our office.***

Responsible Party: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: (_____) _____ _____ _____
Occupation: _____ Social Security Number: _____ - _____ - _____
Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Employer's Telephone: (_____) _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ Social Security Number: _____ - _____ - _____
Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Employer's Telephone: (_____) _____

In the Case of Emergency, Contact: _____ Relationship: _____
(Please provide us with the name and phone number of the nearest relative not living with you.)

Home Phone: (_____) _____ Work Phone: (_____) _____

How did you learn about Allergy & Clinical Immunology Associates? _____

_____

Referred By: Dr. _____

Are other members of your family seen here as patients? If so, please list names: _____

_____

A&CI
ASSOCIATES

Insurance Information

Patient's Name: _____ Today's Date: _____
First Middle Last

(Primary)

Name and Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's S.S.#: _____

Policy Holder's Address: _____

Policy Holder's Employer: _____

Group #: _____ Policy ID#: _____

Effective Date of Coverage: _____ Insurance Company Phone #: _____

(Secondary)

Name and Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's S.S.#: _____

Policy Holder's Address: _____

Policy Holder's Employer: _____

Group #: _____ Policy ID#: _____

Effective Date of Coverage: _____ Insurance Company Phone #: _____

Please remember you are responsible for all fees of non-covered services, deductibles, co-payments and balances of fees not paid by insurance companies which we do not participate with.

Signature of Patient or Legal Guardian: _____ Date: _____

I authorize the release of any medical information necessary to process this claim.

Signed: _____
(patient or authorized person)

Date: _____

I authorize payment of medical and surgical benefits to Allergy & Clinical Immunology Associates.

Signed: _____
(patient or authorized person)

Date: _____

Rev. 1/04

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ALLERGY HISTORY

Date _____

Name _____ (Last) _____ (First) _____ (Middle) Referred by: _____

Date of Birth: _____ Age: _____ Sex: _____ Pediatrician, Internist or Family Physician: _____

Occupation (Adults Only): _____

Address: _____

Phone Number: _____ Work Number: _____

Father's Name (Children Only): _____ Occupation: _____

Mother's Name (Children Only): _____ Occupation: _____

PLEASE ANSWER ALL QUESTIONS

HOSPITALIZATIONS:	REASON	DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

DRUG REACTIONS:

Drug	Symptom

FOOD DISAGREEMENTS:

Food	Symptom	Can Food Now be Eaten?

FAMILY HISTORY:
Please Note Family Member with the Following Diseases:

M – Mother A – Aunt C – Cousin
F – Father U – Uncle
B – Brother GF – Grandfather
S – Sister GM – Grandmother

	Brothers or Sisters	Paternal Relatives	Maternal Relatives
Asthma			
Hay Fever or Allergic Nose Problem			
Eczema			
Insect Allergies			
Drug Allergies			
Food Allergies			
Sinusitis			
Bronchitis and/or Emphysema			
Cystic Fibrosis			
Migraine			
Frequent Infections			
Systemic Lupus Erythematosis			
Rheumatoid Arthritis			
Tuberculosis			
Diabetes			
Heart Disease			
High Blood Pressure			
Cancer			

PREVIOUS DISEASES:

	Yes	No
Measles (Rubeola)	☐	☐
German Measles (Rubella)	☐	☐
Mumps	☐	☐
Chicken-pox	☐	☐
Whooping Cough	☐	☐
Scarlet Fever	☐	☐
Rheumatic Fever	☐	☐
Pneumonia	☐	☐
Bronchitis	☐	☐
Anemia	☐	☐
Jaundice	☐	☐
Tuberculosis	☐	☐
Sinus Infections	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Cancer	☐	☐

Complications in Detail:

ALLERGY HISTORY (Continued)

Name _____ Date Filled Out _____
(Last) (First) (Middle)

INSTRUCTIONS: Check Yes or No. PLEASE ANSWER ALL QUESTIONS.

INFANCY HISTORY

	Yes	No
Full term pregnancy	☐	☐
Complicated pregnancy	☐	☐
Birth wt. _____ lbs. _____ oz.		
Initial Feeding:		
Breast:	☐	☐
To What Age:		
Bottle	☐	☐
Type of formula:		
To what age: _____		
Feedings:		
Tolerated well	☐	☐
Many changes	☐	☐
Vomiting	☐	☐
Spitting	☐	☐
Diarrhea	☐	☐
Whole milk started at _____ months		
Colic 0-3 months	☐	☐
Longer	☐	☐

Age Walked Alone: _____
Age Talked (Short Sentences): _____
Age Toilet Trained: _____

LABORATORY TESTS

	Where Done	Date	Normal	Abnormal
X-ray Chest				
Sinus				
Sweat Test				
TB Skin Test				
Allergy Skin Tests				
Others:				

FAMILY CONSTELLATION

(Applies to Adults)	Yes	No
Married	☐	☐
Single	☐	☐
Divorced	☐	☐
Widowed	☐	☐
(Applies to Children)		
Parents separated	☐	☐
When _____		
Divorced	☐	☐
When _____		
Deceased	☐	☐
Who _____		
When _____		
Cause _____		
Any children deceased	☐	☐
When _____		
Cause _____		

Number of other children: _____
List by age and sex: _____

Other relatives in home ☐ ☐
Who _____
Number of children in Mother's Family _____
Number of children in Father's Family _____
Additional Information: _____

SYSTEMIC REVIEW

GENERAL	Yes	No
Weight loss	☐	☐
Tired all the time	☐	☐
Work missed past year (days)		
School missed past year		

Missed 0-5 days _____
6-10 days _____
11-20 days _____
More than 20 days _____
Performance:
Satisfactory
Explain: _____

IMMUNIZATIONS RECEIVED:	Yes	No
Diphtheria	☐	☐
Tetanus	☐	☐
Whooping Cough	☐	☐
Polio	☐	☐
Smallpox	☐	☐
Hemophilus Influenza B (HIB)	☐	☐
Pneumovax	☐	☐
Measles	☐	☐
German Measles (3 day)	☐	☐
Mumps	☐	☐
Influenza	☐	☐
	☐	☐
	☐	☐
	☐	☐

ALLERGY HISTORY (Continued)

Name _____ Date filled out _____
(Last) (First) (Middle)

INSTRUCTIONS: Check Yes or No. PLEASE ANSWER ALL QUESTIONS.

	Yes	No
NERVOUS SYSTEM		
Headaches	☐	☐
Dizziness or Lightheaded	☐	☐
Fainting	☐	☐
Convulsions	☐	☐
EYES		
Redness	☐	☐
Itch	☐	☐
Tearing	☐	☐
Discharge	☐	☐
Rubbing	☐	☐
Puffiness	☐	☐
EARS		
Pain	☐	☐
Hearing Loss	☐	☐
Infections	☐	☐
Myringotomy (Ears opened)	☐	☐
Tubes Inserted	☐	☐
NOSE		
Frequent Colds	☐	☐
Discharge; if yes, give color of discharge:	☐	☐
Bleeds	☐	☐
Itch	☐	☐
Stuffiness	☐	☐
Constant	☐	☐
Seasonal	☐	☐
Sneezing	☐	☐
Mouth Breathing	☐	☐
Sinusitis	☐	☐
Snoring	☐	☐
Sniffles	☐	☐
THROAT		
Frequently Sore	☐	☐
Frequent Clearing	☐	☐
Bad Breath	☐	☐
Voice Change	☐	☐
Tonsillectomy	☐	☐
Adenoidectomy	☐	☐
Swollen Glands	☐	☐
Itch	☐	☐
Trouble Swallowing	☐	☐

	Yes	No
CHEST		
Wheeze	☐	☐
Summer	☐	☐
Winter	☐	☐
Spring	☐	☐
Fall	☐	☐
Cough		
Deep	☐	☐
Loose	☐	☐
Constant	☐	☐
Dry	☐	☐
Daytime	☐	☐
Nighttime	☐	☐
Exertional	☐	☐
Shortness of Breath	☐	☐
Pain	☐	☐
Heart Pain	☐	☐
Rattle	☐	☐
Sputum or Phlegm	☐	☐
Amount/day		
Color		
GASTROINTESTINAL		
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Gas	☐	☐
Belching	☐	☐
Abdominal Pain	☐	☐
Cramps	☐	☐
Blood in Stools	☐	☐
Mucous in Stools	☐	☐
Fatty or Foul Smelling Stools	☐	☐
Jaundice or Hepatitis	☐	☐
Appetite: Good	☐	☐
Poor	☐	☐
Craves Salt	☐	☐
GENITOURINARY		
Bedwetting	☐	☐
Blood in Urine	☐	☐
Pain	☐	☐
Itching	☐	☐
Day Wetting	☐	☐
Infection (Cystitis or Nephritis)	☐	☐
Is Urine Stream Forceful?	☐	☐

	Yes	No
SKIN		
Cradle Cap	☐	☐
Thrush	☐	☐
Eczema	☐	☐
Cheeks	☐	☐
Bend of Elbows	☐	☐
Behind Knees	☐	☐
Neck	☐	☐
All Over	☐	☐
Hives	☐	☐
Poison Ivy	☐	☐
Insect Bite	☐	☐
Reaction	☐	☐
Local	☐	☐
Generalized	☐	☐

ARE SYMPTOMS AGGRAVATED BY:

	Yes	No
Cutting grass	☐	☐
Dusting	☐	☐
Musty odors	☐	☐
Cold	☐	☐
Rain	☐	☐
Exercise	☐	☐
Smoking	☐	☐
Colds	☐	☐
Animals	☐	☐
Strong odors	☐	☐
Hair spray	☐	☐
Perfume	☐	☐

	Yes	No
FEMALE HISTORY		
Age Menstrual Periods Began:		
Frequency of Periods:		
Date Last Normal Menstrual Period:		
Bleeding Between Periods:	☐	☐
Duration of Periods:		
Excessive Amt. of Bleeding	☐	☐
Number of Pregnancies:		
Number of Miscarriages or Stillbirths:		

PRESENT MEDICATIONS

DRUG	DOSE

Form HIS-103 Rev. 7-91

Name _____ Date filled out _____
(Last) (First) (Middle)

INSTRUCTIONS: Check Yes or No. PLEASE ANSWER ALL QUESTIONS.

ENVIRONMENTAL SURVEY

LIVING ACCOMMODATIONS

	Yes	No
Present Address for ____ yrs.		
House _____ years old		
Apartment	☐	☐
In City	☐	☐
In Country	☐	☐
Suburban	☐	☐
On Farm	☐	☐
Recent Painting or Repair	☐	☐
Basement:	☐	☐
Dry	☐	☐
Damp	☐	☐
Musty Smell	☐	☐
Mildew	☐	☐
Carpeting:	☐	☐
Wool	☐	☐
Synthetic	☐	☐
Cotton	☐	☐
Other	☐	☐
Rug Pad:	☐	☐
Rubber	☐	☐
Hair	☐	☐
House Plants	☐	☐

HEATING SYSTEM

Energy Source:		
Gas	☐	☐
Electric	☐	☐
Coal	☐	☐
Oil	☐	☐
Woodburner	☐	☐
Fireplace	☐	☐
Mode of Delivery:		
Radiators	☐	☐
Hot Air: Blower	☐	☐
Gravity	☐	☐
Radiant (Baseboard)	☐	☐
Electronic Air Cleaner	☐	☐
HEPA Filter	☐	☐
Humidifier	☐	☐
Air Conditioning: Room	☐	☐
Whole House	☐	☐

SMOKING

Patient	☐	☐
Packs per Day: _____		
Father	☐	☐
Mother	☐	☐
Others in Contact	☐	☐
Husband or Wife	☐	☐
Use of Alcoholic Beverage	☐	☐
If yes – amount, type and frequency		

BEDROOM

	Yes	No
Number in Room: _____		
Sleeps in own room	☐	☐
Bed shared with:		
Other child	☐	☐
Parent	☐	☐
Spouse	☐	☐
Pillow:	☐	☐
Feather (down)	☐	☐
Rubber	☐	☐
Kapok	☐	☐
Synthetic	☐	☐
Mattress:		
Regular (cotton, stuffed)	☐	☐
Rubber	☐	☐
Waterbed	☐	☐
Mattress cover:		
Cotton	☐	☐
Plastic Top Cover	☐	☐
Plastic Encasing	☐	☐
Bedspread:		
Cotton	☐	☐
Chenile	☐	☐
Other	☐	☐
Blankets (wool)	☐	☐
Comfort:	☐	☐
Cotton Stuffed	☐	☐
Down	☐	☐
Bedroom rug:	☐	☐
Area	☐	☐
Wall-To-Wall	☐	☐
Wool	☐	☐
Cotton	☐	☐
Synthetic	☐	☐
Shag	☐	☐
Bedroom Rug Underpad:	☐	☐
Ozite (Hair)	☐	☐
Rubber	☐	☐
Stuffed toys	☐	☐
Does child hold or sleep with any object?	☐	☐
If so, what?		

PETS

	Any Contact		In House	
	Yes	No	Yes	No
Dog	☐	☐	☐	☐
Cat	☐	☐	☐	☐
Bird	☐	☐	☐	☐
Horse	☐	☐		
Other	☐	☐		

FAMILY HOBBIES

ADDITIONAL PERTINENT INFORMATION