VICTORIA ALLERGY AND ASTHMA CLINIC

3901 N. NAVARRO
VICTORIA. TEXAS 77901
(361) 573-0713
(800) 392-5797
FAX (361) 575-2215

Robert E. Harvey, M.D.
Diplomate American Board
of Internal Medicine

Gullapalli K. Rao, M.D.
Diplomate American Board
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DIPLOMATES OF THE American Board of Allergy & Immunology
A conjoint Board of the American Board of Internal Medicine, American Board Of Pediatrics and a member of the American Board of Medical Specialities

Thank you for choosing Victoria Allergy & Asthma Clinic. In order to provide you with the best allergy and asthma care, we need current information regarding your medical history, family history and living environment. This information will allow our staff to have quick access to your medical records.

The initial patient consultation and testing will take between one and four hours. If you are unable to keep this appointment, please call us to reschedule.

It is our policy to collect patient balances at time of service. We accept Cash, Check, Visa, MasterCard and Discover.

Patients should bring all of their medication, including over the counter medicines, vitamins and herbal supplements. Certain medicines (anti-histamines and anti-histamine containing medicines such as cough medicines and cold remedies, as well as mood elevators/anti-depressants) need to be discontinued five (5) days prior to the visit to ensure that skin testing results are accurate. *(See attached sheet)* Blood pressure medications, antibiotics and asthma inhalers should **not** be discontinued. If you have a question about a particular medication, contact our nursing staff.

Check location of scheduled appointment:

_____ Victoria:	3901 N. Navarro
_____ EL Campo:	305 Sandy Corner Rd, Ste 210
_____ Beeville:	1211 E. Houston (South Texas Institute of Cancer Bldg.)
_____ Rockport:	2726 Hwy 35 N (Atlas Orthopedics Office)
_____ Weimar:	402 Youens Drive

COMPLETE THIS QUESTIONNAIRE AND RETURN TO 3901 N. NAVARRO, VICTORIA, TX 77901 OR FAX TO (361) 575-2215. IF WE DO NOT RECEIVE THE COMPLETED QUESTIONNAIRE FIVE DAYS PRIOR TO YOUR VISIT, WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.

Thank you in advance for you cooperation. We look forward to seeing you.

Robert E. Harvey, M.D.
Gullapalli K. Rao, M.D.
Beverly Haliburton, RN-FNP
Susan Hall, PA-C

ACCT #:	NAME:	DOB:
APPT DATE:	TIME:	VAAC:

Have you ever been seen at the Victoria Allergy & Asthma Clinic in the past? ☐ **Yes** ☐ **No** **When:** _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME
SS #	MAILING ADDRESS	CITY/STATE/ZIP
DOB	SEX MALE ☐ FEMALE ☐	PATIENT EMPLOYER
HOME PHONE #	WORK PHONE # EXT.	CELL PHONE #
(RESPONSIBLE PARTY): SPOUSE, PARENT OR GUARANTOR		WORK PHONE #
SS #		DOB

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY? NAME:	RELATIONSHIP:	PHONE NUMBER#

NAME OF REFERRING DOCTOR AND PHONE NUMBER

(INSURANCE INFORMATION): PRIMARY INSURANCE NAME	INSURED NAME	
ID # AND GROUP #	INSURANCE PHONE NUMBER	
INSURED SS #	DOB	RELATIONSHIP TO PATIENT
EMPLOYER		
(INSURANCE INFORMATION): SECONDARY INSURANCE NAME	INSURED NAME	
ID # AND GROUP #	INSURANCE PHONE NUMBER	
INSURED SS #	DOB	RELATIONSHIP TO PATIENT
EMPLOYER		

Regardless of insurance status, I understand that I am ultimately responsible for the balance on my account. I certify that the information that I have provided is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Patient Signature
(Parent/Guardian):_____
Date

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner. Any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this cover sheet indicate that you have received a copy of Victoria Allergy & Asthma Clinic's Notice of privacy practices. The notice is yours to keep.
If you have any questions regarding the information set forth in Victoria Allergy & Asthma Clinic notice of privacy practices, contact our office at (361) 573-0713 or (800) 392-5797.

Patient signature (parent/guardian):_____
Date

ALL information must be

<u>COMPLETE</u> or appointment

will be rescheduled.

If you need assistance,

please call nurse.

361-573-0713, Ext. 212

Acct #_____ **Name:**_____ **DOB:**_____
Appt Date:_____ **Time:**_____ **VAAC:**_____

Referring Physician:_____

Preferred Local Pharmacy:_____ **Address:**_____

Preferred Mail Order Pharmacy_____

Ethnic background: ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Other**

REASON FOR VISIT:

☐ **Asthma**	☐ **Eye problems**	☐ **Insect allergy**	☐ **Sinus problems**
☐ **Chest infections**	☐ **Hay fever/Nasal allergies**		☐ **Sore throat**
☐ **Cough**	☐ **Headache**	☐ **Rash/Skin allergies**	☐ **Other**
☐ **Ear problems**	☐ **Hives**	☐ **Shortness of breath**	

Please circle any symptoms you have experienced recently.

GENERAL:

Change in appetite	**Weight gain**	**Change in energy level**
Fatigue	**Weight loss**	**General feeling of being ill**
Fever	**Change in activity**	

SKIN:

Blisters	**Dryness**	**Hives**	**Rashes**
Changing Moles	**Eczema**	**Itching**	**Sores**
Discolorations	**Growths**	**Non-healing lesions**	

EYES:

Watering	**Dryness**	**Pain**	**Scratchiness**	**Problems with vision**
Discharge	**Itching**	**Redness**	**Swelling**	**Glasses/Contact lens**

ENT: (Ears, nose & throat)

Headache	**Runny nose**	**Sleep apnea**
Hearing difficulties or loss	**Post nasal drainage**	**Sinus pressure/pain**
Ear infection	**Throat clearing**	**Snoring**
Ear pain	**Nasal or sinus bleeding**	**Hoarseness**
Ringing in ears	**Nasal congestion**	**Sore throat**
Dizziness	**Sneezing**	**Swallowing difficulties**
		Decreased sense of smell

RESPIRATORY:

Cough productive of blood	**Decreased exercise tolerance**	**Wheezing**
Cough Dry	**Difficulty breathing on exertion**	
Cough productive	**Shortness of breath**	

CARDIAC:

Chest pain, pressure or discomfort	**Pillows used: 1 2 3**
Inability to sleep in flat position	**Rapid heart beat**

GI:

Abdominal pain	**Heartburn**	**Nausea**	**Vomiting**
Appetite change	**Indigestion**	**Regurgitation**	**Food intolerance**

MUSCULOSKELETAL:

Back pain	**Joint: pain, stiffness**	**Muscle: weakness, stiffness or swelling**

Acct #_____ **Name:**_____ **DOB:**_____
Appt Date:_____ **Time:**_____ **VAAC:**_____

NEUROLOGICAL:
Abnormalities in sensation (numbness/tingling) **Difficulty in muscular strength**
Difficulty in consciousness, memory or concentration **Difficulty in walking**

PSYCHOLOGICAL:
Anxiety **Hypersomnia (sleeping too much)** **Stress**
Change in sleep pattern **Insomnia**

ENDOCRINE:
Heat intolerance **Cold intolerance** **Change in hair distribution**

HEMATOLOGIC/LYMPHATIC:
Easy bruising or bleeding **Swollen, tender or painful lymph nodes**
Clotting disorders **Lymphedema**

PAST MEDICAL HISTORY:
Please provide a history of any illnesses or hospitalizations with year of occurrence: (example: high blood pressure, 1987; diabetes 1991; glaucoma 1995) ***(If more space is needed, please add blank sheet.)***

MEDICAL CONDITION	YEAR OF OCCURRENCE

ALLERGIC REACTION YOU HAVE HAD:
Are you allergic to latex or rubber? ☐ **yes** ☐ **no Date of reaction:**_____
Are you allergic to any medications? ☐ **yes** ☐ **no**
If YES, please give the name of the drug and describe the type of reaction: (rash, swelling, wheezing, shortness of breath, loss of consciousness, etc.) ***(If more space is needed, please use the backside of this sheet.)***

MEDICATION	TYPE OF REACTION	DATE OF REACTION

Acct #_____ Name:_____ DOB:_____
Appt Date:_____ Time:_____ VAAC:_____

PLEASE LIST ANY OTHER ALLERGIC REACTION YOU MAY HAVE, SUCH AS INSECTS, X-RAY DYES OR OTHER SUBSTANCES	DATE OF REACTION

FAMILY HISTORY OF ILLNESS: (mark any family members who have experienced any of the listed conditions)

	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	OTHERS
Deceased							
Migraine							
Hives							
Emphysema							
Asthma							
Cystic Fibrosis							
Hayfever							
Sinus							
Other							

SOCIAL HISTORY:

Personal tobacco use: ☐ current ☐ past ☐ never

Tobacco use: ☐ Smokeless ☐ Cigarettes ____ /day Cigars_____ /day

How many years did you/have you smoked?_____ **Year stopped smoking:**_____

Second hand exposure? ☐ yes ☐ no **If yes, who and where?**_____

Do you drink alcohol? ☐ Yes No **If yes, what kind and how much?** _____

_____

Caffeine use (Servings per day): _____coffee _____tea _____carbonated beverages

_____medicines _____foods

Illegal drug use? ☐ yes ☐ no

Do you have any HIV risk factors? ☐ yes ☐ no

Hobbies: _____

Occupation (type of work, student or retired): _____

If retired, what did you do when actively employed?_____

Acct #_____ **Name:**_____ **DOB:**_____
Appt Date:_____ **Time:**_____ **VAAC:**_____

ENVIRONMENTAL HISTORY:
Do you have any pets? ☐ no ☐ cats ☐ dogs ☐ other
Are they: ☐ inside ☐ outside ☐ both
Do the pets sleep in your bedroom? ☐ yes ☐ no
Do you have any feather pillows or bedding (feather comforters, mattress)? ☐ Yes ☐ No
Housing: ☐ house ☐ apartment ☐ other
Home location: ☐ rural ☐ city ☐ suburban ☐ urban ☐ large metropolitan area
Age of house/apartment? _____0-10 years _____10 years +
What type of flooring is in your home? ☐ carpet ☐ linoleum ☐ tile ☐ hardwood ☐ other
What window coverings are in your home? ☐ none ☐ cloth ☐ drapes ☐ wood shutters
☐ plastic/metal blinds ☐ other
What heating/cooling system is in your home? ☐ window units ☐ space heaters ☐ central air/heat other ☐
Has there been any type of water damage or water leakage in your home?
☐ yes ☐ no ☐ uncertain
Do you have any type of fans in your home? ☐ yes ☐ no
Do you have a fan in your bedroom? ☐ yes ☐ no

CHILD CARE:
Attendance: ☐ days ☐ after school ☐ other
Setting: home ☐ daycare ☐

PAST MEDICATIONS:
List all medications tried. *(If more space is needed, please add on blank sheet.)*

MEDICATION	DOSE	FREQUENCY	HOW TAKEN	DATE STARTED	DATE STOPPED

CURRENT MEDICATION:
List all your current medications. Include over the counter medications, eye drops, etc.
(If more space is needed, please add blank sheet.)

MEDICATIONS	DOSE	FREQUENCY	TAKEN FOR	DATE STARTED

Acct #_____ **Name:**_____ **DOB:**_____
Appt Date:_____ **Time:**_____ **VAAC:**_____

Please list all surgeries and YEAR OF OCCURRENCE. Include any prosthetic devices. (Example: pneumonia 1986, tonsillectomy 1972). *(If more space is needed, please add blank sheet.)*

SURGERIES AND PROSTHETIC DEVICES	YEAR OF OCCURRENCE

****If Spanish speaking only, please bring someone that speaks English to help with the translation.****

Stop these Drugs Five (5) Days Prior to Visit

ANTIHISTAMINES

Alavert (Loratadine)
Allegra (Fexofenadine)
Antivert (Meclizine)
Atarax (Hydroxyzine)
Benadryl (Diphenhydramine)
Brompheniramine
Chlor-Trimeton (Chlorpheniramine)
Clarinex (Desloratadine)
Claritin (Loratadine)
Tavist (Clemastine)
Vistaril (Hydroxyzine)
Xyzal (Levocetirizine)
Zyrtec (Cetirizine)

NASAL SPRAYS

Astelin (Azelastine)
Astepro (Azelastine)
Patanase (Olopatadine)

MOOD/ANTIDEPRESSANTS

Please call before stopping these medications

Amitriptyline (Elavil)
Doxepin
Limbitrol (Chlordiazepoxide / amitriptyline)