Welcome to Academy Allergy Asthma and Sinus Center

Before you sign, please read the following information carefully.
I will ask questions and promptly voice my concerns. I will give full and accurate information as it relates to my health, including prescription and non-prescription medications. I will report any changes in my symptoms, including pain, and request assistance from a healthcare team. I will educate myself, learn about the medical tests that will be performed and understand my treatment plan. I will follow my recommended treatment plan. I will be considerate of the staff and other patients. I will follow the facilities rules and regulations. I will respect the property that belongs to the facility or others. I will understand and honor financial obligations related to my care, including understanding my own insurance coverage.

I will make appointments with other providers as recommended by Dr. Patel and his office otherwise I can suffer the consequences such as misdiagnosis, complications and even death. Why? Depending on my progress, during my follow- up visits:

1. Dr. Patel can change my medications: decrease the dose, stop them, or add new medications if needed. If I develop any side effects to the medications, he can evaluate and treat them appropriately.
2. Dr. Patel may recommend some tests to confirm or revise the diagnosis.
3. Dr. Patel can refer me to another specialist.
4. Dr. Patel may come up with some other ideas depending on the advances in medical knowledge.
5. Dr. Patel will discuss the results of my tests; he recommends discussing the results in person, not on the phone.

I understand that I am responsible for any adverse outcomes which may arise because I failed to keep my appointments. If I cannot keep my follow-up appointment, I will reschedule it and I will keep the rescheduled appointment. If I cannot afford my follow-up appointment, I will discuss it with Dr. Patel as he will try his best to help me on a sliding scale. By not keeping the follow-up appointments, I have assumed responsibility for my further medical care including diagnosis, treatment, etc. I release Ashok PC, Dr. Patel, its staff and the treating provider(s) from any liability or medical claims because of my refusing the recommended test, procedure, or treatment.

A gentle reminder: If you missed two (2) follow-up appointments, we may not see you as a patient in our practice. Without adequate follow-up, we cannot deliver good health care to you.

Some patients do not want to take any medications and want to be treated natural way. If Dr. Patel recommends medications, would you consider them?

☐ Yes ☐ No

Patient signature Date

I have read, understood and agreed with Ashok PC's HIPPA policy

Typing your name is equivalent to your handwritten signature

By typing my signature and sending it via the Internet, I acknowledge that I have read and understand all information provided in this form; that I intend Ashok PC to rely upon it; that I intend to be bound thereby; and that I understand and agree that my electronic signature is the equivalent of a manual written signature.

Forms

Most patients tell me that other doctors and providers take history in a different way, by asking questions.

I have found that the following matter works best to get the medical information. Please take your own time and fill out the form. As you'll not be rushed in filling out the form, I will get better information on your medical problems.

If I take history by asking you questions, you may reply in a hurry to save my time. You may not understand my questions and so on. So, I have developed the system of the forms.

Thank you for understanding.

Respectfully,

Ashok R. Patel, M.D.

Date: _____

Name: _____DOB: _____ Age: _____
First *Middle* *Last*

☐Male ☐Female Language: _____ Parent/Guardian Name: _____

Insurance(s):_____ / _____
Primary *Secondary*

Address: _____
City *State* *Zip Code*

Cell#(s): _____ / _____
Home#: _____ Work#: _____
Email(s): _____ / _____

Pharmacy_____Address:_____

Primary Care Physician: _____ Phone#: _____

How did you hear about Dr. Patel?

☐Friends/Family _____ ☐Referral _____
Name/Number *Name/Number*

☐ Internet ☐Previous patient ☐Others_____

Did you get COVID-19 Vaccine? ☐Yes, how many? ____ ☐No **Height:** _____ **Weight:** _____

Are you pregnant? ☐N/A ☐No ☐Yes, weeks: _____

In last 5 days, have you taken any antihistamines? ☐Yes, when? _____ ☐No ☐Not sure

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Please tell us the reason for your visit. *Type on the box below.*

Please answer the questions whichever applies. If not, write/choose N/A, not applicable.

- **Have you been diagnosed with asthma?** ☐Yes, when? _____ ☐No
  - Do you use or have you used in the past an albuterol HFA or a nebulizer? ☐YES ☐NO
  - If yes, how often? ☐1-2 times a day ☐3+ times a day ☐2-3 times a week ☐less than once a week

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- **Tell us about your cough in the last 4 weeks by marking an (X)in the appropriate box.** ☐**N/A**

	None	Mild	Moderate	Severe
▪ Cough at bedtime?	☐	☐	☐	☐
▪ Cough when you first wake up?	☐	☐	☐	☐
▪ Cough in your sleep?	☐	☐	☐	☐
▪ Cough after exercise?	☐	☐	☐	☐
▪ Cough when you talk for prolong amount of time?	☐	☐	☐	☐
▪ Cough when you laugh?	☐	☐	☐	☐
▪ Cough when you sing?	☐	☐	☐	☐
▪ Cough when you cry?	☐	☐	☐	☐
▪ Cough when you drink or eat something cold?	☐	☐	☐	☐
▪ Cough upon cold air exposure?	☐	☐	☐	☐

- **Chest colds:**
  - When you catch a cold, do you develop a severe cough: ☐Yes ☐No
  - How many days the cough will last? _____
  - How many episodes of chest colds in a year? _____
  - What time of the year? ☐Spring ☐Summer ☐Fall ☐Winter

- **Other respiratory symptoms in last 4 weeks:**

	None	Mild	Moderate	Severe
▪ Wheezing	☐	☐	☐	☐
▪ Chest congestion	☐	☐	☐	☐
▪ Shortness of breath	☐	☐	☐	☐

  - Do you expectorate phlegm from the chest? ☐Yes ☐No
    If yes, guess the amount of the phlegm expectorated in 24 hours: _____ teaspoon(s)
  - Have you coughed up blood in the sputum? ☐Yes ☐No
  - Are respiratory symptoms such as phlegm, nasal discharge worse after shower, when exposed to flushing of the toilet or when working with damp soil? ☐ Yes ☐ No

- **Nasal/sinus symptoms** ☐ N/A

	None	Mild	Moderate	Severe
▪ Runny nose	☐	☐	☐	☐
▪ Stuffy nose	☐	☐	☐	☐
▪ Sneezing	☐	☐	☐	☐
▪ Itchy eyes	☐	☐	☐	☐
▪ Watery eyes	☐	☐	☐	☐

▪ Does your nose run like a faucet, with water-like discharge?	☐ Yes	☐ No
▪ Does your nose run when you bend over?	☐ Yes	☐ No
▪ Does your nose run only on one side?	☐ Right	☐ Left
▪ Does your pillow get stained because of runny nose at night?	☐ Yes	☐ No
▪ Any injury to the head?	☐ Yes, when? _____	☐ No
▪ Have you undergone any nasal or sinus surgery?	☐ Yes, when? _____	☐ No
▪ How is your sense of smell? ☐ Normal	☐ Decreased	☐ None
▪ Have you been diagnosed with Nasal Polyp?	☐ Yes, when? _____	☐ No
▪ Number of nasal polyp surgeries? _____		

- Are your respiratory symptoms worse at certain times of the year? ☐ Yes ☐ No

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
▪ Sneezing, Itching, Congestion, Runny nose	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
▪ Watery/Itchy Eye	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
▪ Cough/Wheezing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Did you go for Allergy Skin Test in the past?	☐ Yes, when? _____	☐ No
Have you ever received allergy injections?	☐ Yes, when? _____	☐ No
Have you undergone any Chest X-Rays?	☐ Yes, when? _____ Where? _____ Result? _____	☐ No
Have you undergone CT of the Chest?	☐ Yes, when? _____ Where? _____ Result? _____	☐ No

Please provide us a copy of the reports if possible.

- **SLEEP:** *Please talk to your primary care provider if you have the following issue.*

Excessive Daytime Sleepiness	Snoring	Stop Breathing in Sleep	Do you use supplemental oxygen?
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

- **OTHER MEDICAL PROBLEMS:**

- **MEDICATIONS**:
  - Please write current drugs you are taking that is prescribed by a health care provider.

Name of Drugs	Dosage	How Often?	When it was started?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

  - Please write current over the counter/herbal/supplements you are taking

Name of Drugs	Dosage	How Often?	When it was started?
1.			
2.			
3.			
4.			
5.			

  - ADVERSE REACTIONS TO MEDICATIONS:

Name of Drugs	Symptoms	Treatment	When?
1.			
2.			
3.			
4.			
5.			

- Please list the medications you tried in the past

Name of Drugs	When?	Name of Drugs	When?
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

- **MEDICATION HISTORY**

The following questions ask about specific medications. If you are taking or have ever taken the listed medication, please answer "Yes" and provide the year you began taking this medication.

▪ Amiodarone (Cordarone®)	☐ Yes	☐ No	Date: _____
▪ Nitrofurantoin (Macrobid, Macrodantin®)	☐ Yes	☐ No	Date: _____
▪ Bleomycin (Blenoxane®)	☐ Yes	☐ No	Date: _____
▪ Methotrexate (Folex®, Rheumatrex®)	☐ Yes	☐ No	Date: _____
▪ Prednisone/prednisolone	☐ Yes	☐ No	Date: _____
▪ Cyclophosphamide (Cytoxan®)	☐ Yes	☐ No	Date: _____
▪ Azathioprine (Imuran®)	☐ Yes	☐ No	Date: _____
▪ N-acetylcysteine (NAC)	☐ Yes	☐ No	Date: _____
▪ Gamma-interferon 1-b (Actimmune®)	☐ Yes	☐ No	Date: _____
▪ Mycophenolate (CellCept®)	☐ Yes	☐ No	Date: _____
▪ Colchicine	☐ Yes	☐ No	Date: _____
▪ Bosentan (Tracleer®)	☐ Yes	☐ No	Date: _____
▪ Imatinib mesylate (Gleevec®)	☐ Yes	☐ No	Date: _____
▪ Etanercept (Enbrel®)	☐ Yes	☐ No	Date: _____
▪ Infliximab (Remicade®)	☐ Yes	☐ No	Date: _____
▪ Radiation therapy	☐ Yes	☐ No	Date: _____
▪ Cancer chemotherapy	☐ Yes	☐ No	Date: _____
▪ Busulfan	☐ Yes	☐ No	Date: _____
▪ Diphenylhydantoin (Dilantin®)	☐ Yes	☐ No	Date: _____
▪ Sulfasalazine (Azulfadine®)	☐ Yes	☐ No	Date: _____
▪ Penicillamine (Cuprimine®, Depen®)	☐ Yes	☐ No	Date: _____
▪ Hydralazine	☐ Yes	☐ No	Date: _____
▪ Isoniazid (INH, Nydrazid®)	☐ Yes	☐ No	Date: _____
▪ Procainamide (Procan, Promine,Pronestyl®)	☐ Yes	☐ No	Date: _____
▪ Chlorambucil (Leukeran®)	☐ Yes	☐ No	Date: _____
▪ Gold salts	☐ Yes	☐ No	Date: _____
▪ Cyclosporin A (Neoral® Sandimmune)	☐ Yes	☐ No	Date: _____

- **FAMILY HISTORY:**

Name of Disease	Relationship
1.	
2.	
3.	
4.	
5.	

- **HOSPITALIZATIONS & SURGERIES:**
  - Sinus Surgery ☐ Yes, when? _____ ☐ No
  - Lung Surgery ☐ Yes, when? _____ ☐ No
  - Tonsillectomy ☐ Yes, when? _____ ☐ No
  - Adenoidectomy ☐ Yes, when? _____ ☐ No
  - Others: _____

- **IMMUNE SYSTEM:**

Adult (Ages 18+)

▪ Two or more new ear infections within 1 year	☐ Yes	☐ No
▪ Two or more new sinus infections within 1 year, in the absence of allergy	☐ Yes	☐ No
▪ One pneumonia per year (x-ray proven) for more than 1 year	☐ Yes	☐ No
▪ Chronic diarrhea with weight loss	☐ Yes	☐ No
▪ Recurrent viral infections (colds, herpes, warts, condyloma)	☐ Yes	☐ No
▪ Recurrent need for intravenous antibiotics to clear infections	☐ Yes	☐ No
▪ Recurrent, deep abscesses of the skin, lymph nodes or internal organs	☐ Yes	☐ No
▪ Persistent thrush or fungal infections on skin or elsewhere	☐ Yes	☐ No
▪ Infections with normally harmless tuberculosis-like bacteria	☐ Yes	☐ No
▪ A family history of primary immunodeficiency	☐ Yes	☐ No

Child (Ages 0-17)

▪ Four or more ear infections within 1 year	☐ Yes	☐ No
▪ Two or more severe sinus infections within one year	☐ Yes	☐ No
▪ Two or more months of antibiotic treatment with little effect	☐ Yes	☐ No
▪ Two or more pneumonias per year	☐ Yes	☐ No
▪ Insufficient weight gain or growth delay	☐ Yes	☐ No
▪ Recurrent deep skin or organ abscesses	☐ Yes	☐ No
▪ Persistent thrush in mouth or fungal infection on skin	☐ Yes	☐ No
▪ Need for intravenous antibiotics to clear infections	☐ Yes	☐ No
▪ Two or more deep seated infections	☐ Yes	☐ No
▪ A family history of a primary immunodeficiency	☐ Yes	☐ No

- **REVIEW OF SYSTEMS** *(Please talk to your primary care provider for evaluation of the following symptoms/issues).*

STOMACH

▪ Do you have a burning feeling behind your breastbone (heartburn)?	☐ Yes	☐ No
▪ Do the contents of your stomach move upwards to your throat or mouth (regurgitation)?	☐ Yes	☐ No
▪ Do you have difficulty getting a good night's sleep because of your heartburn and/or regurgitation?	☐ Yes	☐ No
▪ Do you take additional medication for your heartburn and/or regurgitation, other than what the physician told you to take? (Such as Tums, Rolaids, Maalox?)	☐ Yes	☐ No
▪ Spleen removed?	☐ Yes	☐ No

EAR, NOSE, MOUTH, AND THROAT

▪ Earache	☐ Yes	☐ No
▪ Mouth Sores	☐ Yes	☐ No
▪ Ear Infections	☐ Yes, ____/year	☐ No
▪ Throat Tightness	☐ Yes	☐ No
▪ Hearing Loss	☐ Yes	☐ No
▪ Hoarseness	☐ Yes	☐ No
▪ Nosebleeds	☐ Yes	☐ No

BLOOD AND LYMPH NODES

▪ Easy Bleeding	☐ Yes	☐ No
▪ History of blood infection	☐ Yes	☐ No
▪ Enlarged Lymph nodes	☐ Yes	☐ No

HEART

▪ Shortness of breath	☐ Yes	☐ No
▪ Ischemic heart disease	☐ Yes	☐ No
▪ Irregular Heartbeat	☐ Yes	☐ No
▪ Swelling of Ankles/Legs	☐ Yes	☐ No

GENITOURINARY

▪ Urinary Tract Infections	☐ Yes, ____/year	☐ No

MUSCLES AND BONES

▪ Joint Stiffness	☐ Yes	☐ No
▪ Joint Swelling	☐ Yes	☐ No
▪ Joint Pain	☐ Yes	☐ No

NEUROLOGIC (BRAIN)

▪ History of Meningitis	☐ Yes	☐ No
▪ Headaches	☐ Yes	☐ No

PSYCHOLOGIC (MOOD)

▪ Mood Swings	☐ Yes	☐ No
▪ Panic Attacks	☐ Yes	☐ No

- **HIVES, WELTS, URTICARIA, AND ANGIOEDEMA QUESTIONNAIRE** ☐**N/A**

1. Give us an overview:

_____

_____

_____

2. How long have you been suffering from hives?
   _____ days _____ weeks _____months

3. Do your hives come and go?
   ☐ Yes ☐ No

4. How long does hives, welts, or swelling last in one spot before it completely disappears or moves to other parts of the body?
   ☐_____ minutes ☐_____ days
   ☐ _____ hours ☐_____ weeks

5. When your hives go away, what happens to your skin?
   ☐Goes back to its usual form
   ☐Leaves a bruise
   ☐Leaves a mark
   ☐Others: _____

6. How do hives feel like?
   ☐Itchy ☐Painful
   ☐Burning ☐Others: _____

7. Where does the hives occur? (Body part)

☐Face ☐Trunk/Torso ☐Legs ☐Soles
☐Arms ☐Palms ☐Buttock ☐Others:_____

8. Food/Drugs/others you have ingested 6 hours prior to the hives formation:

_____
_____

9. Where do your hives mostly occur? (place/events)

_____
_____

10. Do they appear when you are stressed?

☐ Yes ☐ No

11. Do you get hives when you come in contact with any of the following?

☐Soap, specify: _____
☐Perfumes, specify: _____
☐Aerosol (hair sprays, air freshener, insect repellant, paints etc.), specify: _____
☐Animals, specify: _____
☐Cosmetics, specify: _____
☐Others: _____

12. Recent travels for the last 3-6 months, specify location: _____

- **ALLERGIC-REACTION OR ANAPHYLAXIS QUESTIONNAIRE** ☐**N/A**

To evaluate your reaction calls for team work. Based on the information you provide; I will recommend further evaluation and treatment. Please take your own time to answer the following questions regarding the allergic reaction; try your best to remember details of the event.

1. Give us an overview of your reaction:

_____
_____
_____

2. Describe your symptoms:

_____
_____
_____

3. In your opinion, what caused the symptoms?

_____

4. What did you ingest within 6 hours of the reaction? And how much?

☐ Food, specify: _____
☐ Prescription and OTC Drugs, specify: _____
☐ Alcohol, specify: _____
☐ Supplements, specify: _____
☐ Others, specify: _____

5. How long does the symptoms last?

☐_____ minutes ☐_____ hours ☐_____ days ☐_____ weeks

6. Where did the reaction happen?

☐Home ☐Work ☐School ☐Indoors
☐Outdoors ☐Medical Facility (such as operating room or imaging facility) ☐Others: _____

7. What were you doing 6 hours prior to the reaction?

_____
_____

8. What time did the reaction happen?

☐Day ☐Night

9. Any bite or stings from insects such as bees, wasps, ants, kissing bugs, spiders etc.?

☐Yes, specify: _____
☐No

10. Did you use latex before the reaction? (Latex gloves, condoms, rubber bands, balloons, bandages etc.)

☐Yes, specify: _____
☐No

11. Were you exposed to a known allergen before the reaction?

☐Yes, specify: _____
☐No

12. Any physical factors such as cold temperature or heat play a role in the reaction?

☐Yes, specify: _____
☐No

13. Did you take ibuprofen or naproxen several hours before the outbreak of the hives?

☐Yes, Specify: _____
☐ No

13. Is your reaction related to your menstrual cycle?

- ☐ Yes, specify: _____
- ☐ No

14. Do you think inhalant exposure caused the reaction?

- ☐ Yes, specify: _____
- ☐ No

15. What did you do to relieve the symptoms?

_____

16. What treatments were administered?

- ☐ EpiPen Injection
- ☐ Over the counter Medications
- ☐ Medication name/s: _____
- ☐ Emergency Room visit
- ☐ Hospitalization
- ☐ None
- ☐ Others: _____

a. Did the symptoms resolve? ☐ Yes ☐ No

b. If you went to Urgent Care or hospital, what did the health care provider tell you and what medications did you receive?

_____

17. Did the symptoms recur?

- ☐ Within _____ minutes
- ☐ Within _____ hours
- ☐ Within _____ days
- ☐ Within _____ weeks

18. Are you having recurrent episodes of the reaction?

- ☐ Yes, specify: _____
- ☐ No

19. When was the last reaction?

_____

20. Since your reaction, are you avoiding any trigger?

☐Yes, specify: _____

☐No

21. Has any health care provider ordered tests on you to evaluate the reaction? Please provide us with a copy of the test results.

☐Chest X-Ray

☐CT scan

☐Allergy Tests

☐Others: _____

SMOKING/SUBSTANCE USE HISTORY

☐ Never

☐ Current ☐ Former

☐ Cigarette

- What year did you start smoking? _____
- On average, how many cigarettes do/did you smoke per day? _____
- What year did you stop smoking? _____

☐ Pipe (more than 12 oz tobacco in your life)

- Total no. of years you smoked pipe? _____

` ☐ Cigar

- On average, how many cigars do you smoke per week? _____
- Total no. of years you smoked cigar? _____

☐ E-cig/Vape ☐ Marijuana ☐ Cocaine ☐ IV drugs

How often?_____ How often?_____ How often?_____ How often?_____

☐ Smokers at home

- **ALCOHOL USE**
  - Do you drink Alcohol?

    ☐Yes _____/day _____/week _____/month _____/year

    What do you drink?

    _____

    ☐No
  - Have you had any problems with alcohol?

    ☐ Yes ☐ No

FOOD/DRUG ALLERGY QUESTIONNAIRE

Are you on any special diets? Yes ☐ No ☐

Are you avoiding any foods/drugs? Yes ☐ No ☐ **If yes**, please list in the table below:

Name of Food/Drug			
Amount of Food/Drug Ingested			
Symptoms			
How quickly the symptoms start?	Immediately Within minutes _____ minutes Within hours ____hours Within days _____ days	Immediately Within minutes _____ minutes Within hours ___hours Within days _____ days	Immediately Within minutes _____ minutes Within hours ____hours Within days _____ days
Duration of Symptoms			
What did you do for the treatment?			
When did the reaction happen?			
Have you eaten the food again?			
If so, was there a reaction again?			

Eye Symptoms

We ask you the following questions to assess your allergies; we are not eye doctors so we will not evaluate you for symptoms such as vision issues, eye pain, eye infections, glaucoma and other diseases of the eyes.

Please continue care with other doctors including your eye doctor.

	NONE	MILD	MODERATE	SEVERE
Itchy eyes	☐	☐	☐	☐
Watery eyes	☐	☐	☐	☐
Redness of the eyes	☐	☐	☐	☐
Excess tearing/watering	☐	☐	☐	☐
Itchy eyelids	☐	☐	☐	☐
Dry eyelids	☐	☐	☐	☐
Burning	☐	☐	☐	☐
Mucous Discharge	☐	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐	☐
Eczema of eyelid	☐	☐	☐	☐
Loss of vision	☐	☐	☐	☐
Eye pain/soreness	☐	☐	☐	☐
Blurred Vision	☐	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	☐
Double vision	☐	☐	☐	☐
Flashes in Vision	☐	☐	☐	☐
Floaters in Vision	☐	☐	☐	☐
Stye	☐	☐	☐	☐
Chronic infections	☐	☐	☐	☐
Tired eyes	☐	☐	☐	☐
Drooping eyelid	☐	☐	☐	☐
Prominent Eyes	☐	☐	☐	☐

	YES	NO
Do you wear glasses? If yes, how old is your prescription? _____	☐	☐
Do you wear sunglasses?	☐	☐
Do you wear contact lenses? If yes, are they comfortable? Type of contact lenses: _____	☐ ☐	☐ ☐

- **OCCUPATIONAL HISTORY**
  - Are you currently working? ☐ Yes ☐ No ☐ Retired
  - Occupations: Current: _____ Past: _____
  - Are you exposed to anything at work that might aggravate your condition?
    ☐Yes, specify: _____
    ☐No
  - Are your symptoms better on off days, weekends, holidays, or vacation? ☐ Yes ☐ No
  - Have you ever worked in a dusty environment? ☐ Yes ☐ No
  - Have you ever been exposed to gas fumes or chemicals? ☐ Yes ☐ No
  - Other exposure concerns? _____
  - The following questions ask about specific jobs or hobbies you may have had in your life. Tick on the following if you have ever worked as one.

☐Pottery Worker	☐Sandblaster	☐Carpenter/woodwork	☐Longshoreman	☐Textile worker
☐Cotton mill worker	☐Rock miner	☐Plastic worker	☐Housecleaner	☐Paper product worker
☐Pipe worker/plumber	☐Talc worker	☐Mica worker	☐Smelter/Foundry work	☐Cement/ cement product worker
☐Insulation worker	☐Beryllium worker	☐Railroad worker	☐Welder	☐Road builder/tunnel construction work
☐Farmer	☐Aluminum worker	☐Painter/spray painting	☐Insulation worker (pipe/boiler, bulkhead linings, filler, grouting)	☐Automotive product worker (brake linings, gaskets, clutch plates etc.)

- **ENVIRONMENTAL HISTORY**
  The following questions ask about specific exposures you may have had in your home environment. If you were REGULARLY OR REPEATEDLY exposed to any of the following in the THREE YEARS BEFORE your breathing problem started, answer "Yes" and provide any additional information requested.

▪ Humidifier	☐Yes	☐No	
▪ Air cleaner/purifier	☐Yes	☐No	
▪ Steam sauna/steam shower	☐Yes	☐No	
▪ Indoor hot tub	☐Yes	☐No	
▪ Swamp cooler	☐Yes	☐No	
▪ Water damage or mold/mildew in the home	☐Yes	☐No	
▪ Asbestos	☐Yes	☐No	
▪ Down pillows or comforters	☐Yes	☐No	

▪ Pigeons, parakeets or other birds	☐Yes	☐No	*Kind:* _____
▪ Dogs, cats, rabbits, gerbils, hamsters or guinea pigs in house?	☐Yes	☐No	*Kind:* _____
▪ Does the house or office smell musty?	☐Yes	☐No	
▪ Has there been a history of flooding?	☐Yes	☐No	
▪ Is there water damage on the walls or ceilings?	☐Yes	☐No	*Take pictures*
▪ Do you have a lot of plants in the house or office?	☐Yes	☐No	
▪ Do you have fish tanks?	☐Yes	☐No	
▪ Are there any appliances or sinks that leak water Yes No or have a water pan to change?	☐Yes	☐No	
▪ Does your dishwasher leak/overflow?	☐Yes	☐No	
▪ Do you own a Sleep-Number (or equivalent) bed?	☐Yes	☐No	
▪ Do any leather clothes or shoes stored in the closets have a fine layer of white or black covering them?	☐Yes	☐No	*Take pictures*
▪ Are the walls of the closets discolored or have a film of black or white covering them?	☐Yes	☐No	*Take pictures*
▪ Do you have carpeting? Do you get it steam-cleaned regularly?	☐Yes ☐Yes	☐No ☐No	*How old is it?* _____
▪ Do you work with potting soils or compost on a regular basis?	☐Yes	☐No	
▪ Do you hunt in duck blinds or have exposure to moist soil?	☐Yes	☐No	
▪ Do you sleep on a sleep number bed?	☐Yes	☐No	

I understand that Dr. Patel will not evaluate and treat all the symptoms I have marked above in this form. After he talks to me and examines me, he will decide which symptoms and medical problems he will evaluate and treat.

By filling out this form and contacting Dr. Patel's staff, I have not become Dr. Patel's patient and I have not established a doctor-patient relationship with Dr. Patel , Ashok PC or its affiliates.

_____ _____

Signature of the Patient/Guardian Date

I have read, understood and agreed with Ashok PC's HIPPA policy

https://www.mybestallergist.com/privacy-policy

Typing your name is equivalent to your handwritten signature
By typing my signature and sending it via the Internet, I acknowledge that I have read and understand all information provided in this form; that I intend Ashok PC to rely upon it; that I intend to be bound thereby; and that I understand and agree that my electronic signature is the equivalent of a manual written signature.

Patient's Name: _____ Nickname: _____ Date: _____

Who came with you today? _____

Name of insurance paying for your prescriptions: _____

Did the patient take antihistamines in the last 4 days? ☐ Yes ☐ No If yes, give date: _____

Can the child swallow tablet? ☐ Yes ☐ No ☐ Show the Video!

Main MA_____ Helping MA_____ Intake MA_____

☐ Give the welcome binder!

VITAL SIGNS: Temperature: _____F. Pulse: _____/minute. Respirations: _____ /minute.

Blood Pressure: _____/_____ mmHg O2 Sat: _____%

Height_____ In. Weight: _____ lbs.

Pharmacy Name: _____ Phone #:_____ M.A. initial _____

Assessment Plan