Northern Valley Allergy
Asthma & Sinus Center
PATIENT MEDICAL HISTORY QUESTIONNAIRE (ALLERGY)

Patient Name: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____ Tel: _____

Sex: _____ Date of birth: _____ Age: ____ Referred by: _____

Pharmacy of choice: _____ Phone #: _____ SSN: _____

Primary Care Doctor: _____ Doctor Phone#: _____

Reason for your visit: _____

Describe the most distressing symptoms caused by your medical problem:

_____

_____

When did symptoms begin? _____ How often they occur? _____
Worse at night or day? _____ How long do symptoms last? (hours, days, etc.) _____
Circle seasonal pattern: Spring Summer Fall Winter ***ALL YEAR***

What relieves symptoms or causes them to go away? _____

_____

What makes the symptoms worse?

_____

List all **medications** you have tried in the past to relief these symptoms and the response you have had to each (including over the counter medications):

Medication	Relief	No Relief	Side Effects

All current medications (including allergy medications, nutritional supplements, vitamins, herbals):

_____

_____

_____

_____

Have you taken any allergy medications within the last 7 days? Yes / No

If yes, which one(s) and dosage(s): _____

Known Allergies (circle all that apply)**:**

Allergy to foods: Milk, cheese, eggs, fish, shellfish, nuts, peanuts, vegetables, melon, strawberries, wheat, rice, soy, other:_____

Allergy to: X-Ray Dye: Yes / No **Latex** (balloons, condoms…): Yes / No

Allergy to medications (which):_____

_____

Past Medical History: Do you have any pain? Yes / No **Pain Scale**: (0=none; 10=intense) ___/10

Have you ever had any: **Allergy skin test**? Yes / No **Allergy Blood Test?** Yes / No

Date of testing: _____ Physician's name: _____

Have you ever been on allergy shots? Yes / No Date(s): _____

Do you have **asthma**? Yes / No (* <= less than,** >= greater than)

Day symptoms: <* 2 times a week, >**2 times a week, every day, continuous

Night symptoms: <*2 times a month, >**2 times a month, >** 1 time a week

Do you have **frequent infections** (sinus, lungs, bacterial)? Yes / No

Have you had a sinus infection? Yes / No If yes, how often per year: _____

Have you ever had a sinus X-ray or CT? Yes / No Date(s): _____

Have you been **stung** by an insect (bee/wasp/hornet/yellow jacket)? Yes / No Reaction: _____

Do you have Skin Problems: Eczema, Hives, _____ ? Seen by a Dermatologist? Y/N

Other Medical Problems: _____

_____

History of Surgeries / Year _____

_____

Social/Environmental History:

Do you live in a house or apartment? _____ How old is the home: ___ years old

How long have you lived in New Jersey? _____

How long have you lived in your current home? _____ Is there any obvious mold problem? Y / N

Heat: Forced hot air / Gas / Oil / Radiator / Electric Air Conditioning: Central / Window

Type of floor in your bedroom: Carpeting / Hard wood / Tile / Other: _____

Type of bedding: Comforter: down/synthetic Pillow: feather/synthetic/polyester

Do you have any: Stuffed animals/ Upholstered furniture

Window Coverings: Blinds /Upholstered blinds / Drapes

Pets: Dog / Cat Other:_____

Indoors Y / N, If Indoors, in the bedrooms Y / N, if in bedroom are they on bed Y /N

Basement: Damp / Musty / Flooding Cockroaches: Yes / No

What type of laundry detergent do you use? _____Fabric softener?_____

Environmental control: Bedding encasements, HEPA filter, other: _____

History of smoking: Yes / No How long? _____ Packs per day: _____ Prolonged cigarette smoke exposure ("second hand smoke"): Yes / No

Do you drink alcohol? Yes / No How often? _____ Drugs: _____

Occupation: _____Employer: _____

Hobbies: _____

Review of Systems (please circle all symptoms you experience):

General: Weight loss/gains
Stress Drainage
Fatigue Hearing loss
Nervousness Itching
Fainting Pressure
Dizziness
Sinus trouble
Trouble sleeping
Itching
Other: _____

Headaches: Location (front, back, right, left)
How often: _____
Known cause:_____
Vision problems
Vomiting/Nausea
Better with sleep/on weekends
Worse with Tension/Stress
Other: _____

Eyes: Redness
Tearing
Itching
Puffiness
Glaucoma/cataracts
Blurring Vision
Other: _____

Nose: Sneezing
Stuffiness
Clear/cloudy discharge
Itching
Post nasal drip
Loss of smell
Snoring/Apnea
Frequent Bleeding
History of polyps / broken nose

Ears: Frequent infections
Drainage
Hearing Loss
Itching
Pressure
Other: _____

Tongue: Swelling
Sores
Itching
Coating
Loss of Taste
Other: _____

Mouth/Throat: Itching of roof
Recurrent tonsillitis
Sore Throat
Frequent throat clearing
Swelling of lips
Trouble swallowing
Mouth breathing
Bad breath
Change of voice
Other: _____

Chest: Shortness of breath/Tightness
Wheezing
Pain
Cough
Heart Palpitations
Other: _____

Psychiatric: Depression
Anxiety
Other:_____

Digestive Tract: Nausea/ vomiting
Appetite changes
Heartburn/history of reflux
Change in bowel habits
Gas/cramping
Worse after eating
Which foods: _____
Other:_____

Skin: Rash
Hives
Dryness
Blisters/open sores
Itching
Swelling
Burning
Stinging
Redness
Perspiration
Dandruff
Other: _____
Which body part: _____

Kidney: Flank Pain
Frequent urination
Frequent bladder infections
Other: _____

Females: Abnormal menstrual periods
Menopause
Pregnant Yes / No
Last Menstrual Periods: _____
Breastfeeding: Yes / No
Are you planning to become pregnant: Yes / No

Birth History: Weight _____, Breast-fed or formula (which)_____
Type of delivery (natural/Caesarian), gestational age _____

Childhood Problems:_____

_____

Have any growth or developmental problems been found? Yes / No
If Yes, What?_____

Immunizations: Are your Immunizations up to date? Yes / No
When was your last tetanus shot? _____
When was your last pneumonia shot (Pnumovax or Prevnar)? _____
When was your last flu shot (Influenza)? _____

Family History: (Indicate all "yes" answers with a "Y")

	Father	Mother	Brothers	Sisters	Children	Other
Migraine						
Hives						
Emphysema						
Asthma						
Cystic Fibrosis						
Eczema						
Hay Fever						
Tuberculosis						
Thyroid Disease						
Glaucoma						
Sinus Problems						
Frequent Colds						
Cancer						
High blood pressure						
Diabetes						
Heart Disease						
Sudden death						
Autoimmune Disease						
Immunodeficiency						
Other						

Please list anything not discussed in this questionnaire that you consider important to share with your doctor: (all responses are confidential)

_____

_____

_____

_____

Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Northern Valley Allergy, Asthma & Sinus Center medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Northern Valley Allergy, Asthma & Sinus Center to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Northern Valley Allergy, Asthma & Sinus Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

Northern Valley Allergy Asthma and Sinus Center

Authorization for Disclosure of Protective Health Information

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

_____ Myself only _____ My spouse, significant other, or parent (specify name)_____

Other (specify name)_____

Please check your choice on information to be disclosed

_____ Yes, I give my permission for medical information to be left on my answering system.

Please check if yes! _____ Lab/Test results_____ Diagnosis _____ Prescriptions

_____ No, I do not want medical information left on my answering system.

I, _____, have received a copy of this office's Notice of Privacy

I understand that I have the right to revoke this authorization in writing to the office manager at the below address. I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State law.

MEDICATION HISTORY AUTHORIZATION

I also hereby give Northern Valley Allergy, Asthma and Sinus center permission to retrieve all of my medication records from my pharmacy.

_____ _____

Signature of patient or personal representative Date

_____ _____

Print name of patient or personal representative Date

_____ _____

Relationship of personal representative to patient Date

NASAL ENDOSCOPY CONSENT FORM

Patient Name:_____ **DOB:**_____

Nasal Endoscopy: How do we look into your nose / sinuses? **When you come to the Allergy and Asthma Center (AAC) with a nose or sinus related problem, the doctor(s) may want to perform a nasal endoscopy. This is a surgical procedure using sterile small cameras to look through the nostrils. This may allow your doctor to:**

1. **obtain drainage for culture**
2. **evaluate previous surgery, scar, openings, masses, polyps, causes of blockage**
3. **evaluate healing or complications of surgery**
4. **obtain specimens / biopsy for pathology evaluation**
5. **remove old blood, foreign material, packing, scabs/scar/blockage**
6. **educate you and others**

The nurse will have you sign this permission form first and then offer to spray your nose to make the procedure easier. The spray is a combination of Afrin (to shrink tissue) and Lidocaine (to numb). This spray does taste bad and can cause teeth/throat numbness that wears off in about 20-30 minutes. Some patients may also have a sensation that they can't swallow - do NOT panic – this will pass. Two words you need to remember during this procedure:

"Ouch": allows us to know where it is tender

"Sneeze": allows us to get outta there fast

A few patients experience significant discomfort/pressure during the procedure. We will stop if this occurs. Less than 5% of patients faint/get queasy also - called a vasovagal reflex - we will put these patients chairs back and allow them to relax for a few minutes and this goes away.

YOUR CONSENT:

The procedure and description of this procedure, the more common risks associated with it and the potential complications have been described to me. This includes: a small amount of pain/pressure, a mild amount of bleeding, and a reaction to the nasal spray. I have had an opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize the AAC personnel to perform a sinus / nasal endoscopy. I hereby authorize the doctor or his/her associates, to provide such additional services as he or they may consider medically advisable, including but not limited to suctioning, culturing the drainage, biopsies and packing if needed. I also consent to the use of photographs/video images to advance medical education and understand that if any photographs are used, I will not be identified by name.

This consent is valid for one year as of today's date. Thank you!

_____ _____

Patient's Signature / Legal Guardian **Date**

(PLEASE KEEP FOR YOUR RECORDS)
NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical
or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you or to check you out at the reception desk. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorizations. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.