Cool Springs Allergy Associates PLC

1623 Galleria Boulevard
Brentwood, TN 37027
615-771-8800

251 Hillcrest Drive, Suite 101
Clarksville, TN 37043
931-645-5689

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE LET US KNOW 24 HOURS IN ADVANCE

PATIENT INFORMATION: NAME_____ DATE:_____

LAST FIRST MIDDLE INITIAL MALE_____ FEMALE_____

ADDRESS: _____ MARRIED_____ SINGLE_____ MINOR_____

CITY: _____ STATE_____ ZIP _____ BIRTHDATE_____

CELL PHONE: _____ HOME PHONE: _____ WORK:_____

EMPLOYER/SCHOOL: _____ GRADE: _____ SSN:_____

EMAIL:_____ PRIMARY CARE DOCTOR: _____

SPOUSE/PARENT/GUARDIAN _____

_____

PRIMARY INSURANCE HOLDER

NAME:_____ BIRTHDATE:_____

RELATIONSHIP TO THE PATIENT:_____

SSN:_____ CELL PHONE:_____ WORK:_____

ADDRESS IF DIFFERENT FROM PATIENT:_____

EMPLOYER:_____ PRIMARY INSURANCE:_____

ID# _____ GROUP#_____

SECONDARY INSURANCE: _____ ID#_____ GROUP#_____

EMERGENCY CONTACT NAME/PHONE #_____

ARE ANY FAMILY MEMBERS TREATED IN OUR OFFICE? YES_____ NO_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

AGREEMENT: As a courtesy, we file insurance provided the patient furnished all information necessary. I understand that the portion of my treatment not covered by insurance is due and payable at each visit, I also understand that my insurance is a contract between my family and the insurance carrier and not between the insurance carrier and the doctor and I am responsible for all fees. If my insurance has not paid their portion within 60 days of being properly billed, I understand that the balance will become due and payable from me. If I do not pay the entire amount due on my statement within 60 days of the date of service my account could be turned over to collections and any fees involved in this will be my responsibility.

CONSENT: I have read the above information and give my permission to the office of Cool Springs Allergy Associates PLC to utilize diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients medical needs and to file my insurance claims and if need be to forward my medical records to my insurance company if they so require to process claims on my behalf. This agreement also gives our doctors and staff authorization to release information to my pharmacy for new prescriptions or refills to be called in by phone or electronically, to call my cell, home, work place, or any other telephone number I provided. Messages may be left on my answering machine or with family members.

SIGNATURE_____ DATE_____

WITNESS:_____

Cool Springs
Allergy Associates

Patient's Name _____

Last First Middle

Date of Birth _____

Referred by _____

CHIEF COMPLAINT (Please decribe your symptoms in the space provided below)

_____

_____

ALLERGY HISTORY:
CHECK THE SYMPTOMS THAT PROMPTED YOUR VISIT

NOSE & HEAD:

Itchy Nose ____
Sneezing ____
Stuffy Nose ____
Runny Nose ____
Post Nasal Drainage ____
Sore Throat ____
Coughing ____
Hoarseness ____
Loss of Voice ____
Headache ____
Sinus Infections ____
Itchy Eyes ____
Red Eyes ____
Watery Eyes ____
Eye Swelling ____
Itching Ears ____
Blocked Ears ____

CHEST:

Wheeze ____
Shortness of Breath ____
Tight Chest ____
Smothering ____
Chest Infection ____

SKIN:

Hives ____
Eczema ____
Itching ____
Swelling ____

INSECT STING:

Life-Threatening Reaction ____

Approximately how many years have you had your symptoms:

a) Head and nose _____ years
b) Chest _____ years
c) Skin _____ years

FOR OFFICE USE ONLY
DATE: _____

Referred by:

Chief Complaint:

History of Present Illness:

FOR OFFICE USE ONLY

Problems: Seasonal _____
Year round _____

Do you have increased symptoms from any of the following?

A) ALLERGENS
- ☐ Mowed grass
- ☐ House dust
- ☐ Cats
- ☐ Dogs
- ☐ Mold
- ☐ Musty places
- ☐ Dead leaves
- ☐ Hay
- ☐ Pollens

B) IRRITANTS
- ☐ Smoke
- ☐ Outside dust
- ☐ Odors
- ☐ Perfumes
- ☐ Paint
- ☐ Fumes
- ☐ Hair spray
- ☐ Soaps
- ☐ Detergents

HEADACHES: ☐ Yes ☐ No
☐ Occasional

Location (frontal, top, back, cheeks, temples) or others _____
Frequency (times per week or month)_____
Duration (minutes, hours, days) _____
Character (throbbing, sharp, dull)_____
Relief (e.g., medications, sleep, etc.) _____
Aggravating Factors (stress, infection, etc.)

FOODS
Food allergies with description of reaction:

PREVIOUS ALLERGY EVALUATION
Have you seen an allergist before ☐ Yes ☐ No
If so, when? _____
Do you have skin test results? ☐ Yes ☐ No
(If so, please bring skin test results to our office)
Have you ever been on allergy shots? ☐ Yes ☐ No
If so, are you still taking them? ☐ Yes ☐ No
If not, Approximately how long did you take them? _____
When did you quit?_____

Your last Chest X-ray:
When? _____
Why? _____
Results?_____
Ordered by: _____
Dr. _____

Last Sinus X-ray:
When? _____
Why? _____
Results?_____
Ordered by: _____
Dr. _____

REVIEW OF SYSTEMS:

CONSTITUTIONAL SYMPTOMS: fever, weight loss/gain

CNS: headaches, dizziness, numbness, fainting

OPH: blurred vision, double vision, photophobia

ENT: puritic nose, nasal congestion, PND

PULMONARY: SOB, wheeze, chest tightness

CARDIAC: chest pains, palpatations, irregular heart beat

GI: nausea, vomiting, constipation, diarrhea

ENDOCRINE: polyuria, polydypsia, temp instability

HEM/ONC/LYMPH: bleeding, swelling, bruising

INFECTIOUS: recurrent, difficult to treat, life threatening

MUSCULOSKELETAL/RHEUMATOLOGIC: arthritis, muscle weakness

myalgia, arthralgia

SKIN: puritis, rashes, boils

PSYCHIATRIC: depression, insomnia

Patient: Page 2

ENVIRONMENTAL SURVEY **(please check all that apply)**

Any Pets ☐ Yes ☐ No Inside house? ☐ Yes ☐ No List Inside Pets: _____

Do you smoke? ☐ Yes ☐ No If no, in past? ☐ Yes ☐ No Anyone else smoke inside the house? ☐ Yes ☐ No

Any mold problems in house? ☐ Yes ☐ No

Type of heating? ☐ Central ☐ Radiant ☐ Wood ☐ Kerosene ☐ Other: _____

PAST MEDICAL HISTORY

List all hospitalizations and surgeries in order of most recent:

CAUSE OF HOSPITALIZATION	YEAR		YEAR
1.		4.	
2.		5.	
3.		6.	

What other conditions are you being treated or followed for: _____

_____

_____

Past medical conditions or injuries: _____

_____

If patient is a child, are immunizations up to date? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No

MEDICATIONS

Please list all current medications you are taking to relieve your **ALLERGY** symptoms:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list all **OTHER** medications you are taking regularly:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any medications you take **OCCASIONALLY** (e.g. Tylenol, sleeping pill, etc.):

1. _____ 2. _____

DRUG ALLERGIES

Please list all medications to which you are allergic:

_____

_____

FAMILY HISTORY (Please check any that apply)

	Mother	Father	Sisters	Brothers	Children	Others
Asthma	❑	❑	❑	❑	❑	❑
Hayfever	❑	❑	❑	❑	❑	❑
Sinus Problems	❑	❑	❑	❑	❑	❑
Immune Deficiency	❑	❑	❑	❑	❑	❑
Eczema	❑	❑	❑	❑	❑	❑

SOCIAL HISTORY

Employment/School: Where are you employed/or where do you go to school? _____

_____

Job Description: _____

Does anything at work bother your allergies? _____

Number of days missed from work/school per year because of allergy, sinus, or asthma problems? _____

If patient is a child, does he/she attend day care? ❑ Yes ❑ No

How many people are living at home? _____

Recreation: Please list your favorite hobbies: _____

Patient: _____

Reviewed and discussed

Doctor Signature: _____ Date: _____

IDENTIFICATION OF PERSONAL REPRESENTATIVE

Patient name _____ **DOB** ____/____/_____

I hereby grant the individual named below access to my protected health information. This individual may receive and act upon information received from **COOL SPRINGS ALLERGY ASSOCIATES, PC.** This information may include clinical information about my care, as well as billing information related to my insurance coverage and payment activity for services rendered by **COOL SPRINGS ALLERGY ASSOCIATES, P.C.**

- I understand I may revoke this authorization at any time.
- I understand that I have the right to review the information being disclosed to my personal representative.
- I also understand that the protected health information released to my personal representative may be further disclosed by the recipient. **COOL SPRINGS ALLERGY ASSOICATES, P.C.** cannot guarantee the further safeguarding of the health information after the disclosure.
- I acknowledge that I have received a copy of **COOL SPRINGS ALLERGY ASSOCIATES, P.C.** privacy practice notice regarding privacy of personal health information.

Patient signature _____ Date ____/____/_____

Personal Representative _____ DOB ____/____/____ Daytime Phone _____
Personal Representative _____ DOB ____/____/____ Daytime Phone _____
Personal Representative _____ DOB ____/____/____ Daytime Phone _____
Personal Representative _____ DOB ____/____/____ Daytime Phone _____