



Welcome to Our Clinic! **(What to Expect On Your First Visit)**

We want to thank you for choosing us to be a partner in your healthcare! We look forward to meeting you and your family and helping you with your diagnosis and developing a successful treatment plan to solve all of your allergy problems. Your quality of life is our number one priority. Please take a moment to review the following information so your appointment will run smoothly. An allergy evaluation requires a thorough history and testing at the first visit and takes longer than most other doctor's visits.

Allergy Evaluation and Testing:

- Usually, your first visit takes 2 to 2½ hours at the clinic.
- You will be interviewed by several team members during your evaluation and testing will be performed on the day of the visit. Our board certified allergy physician will be involved with all of these procedures. Sometimes lung function testing is necessary. Skin testing is performed on the back and takes 15-30 minutes and is fairly painless. It is performed using a plastic pick to prick the skin and doesn't puncture the skin.
- The physician will meet with you and make any necessary recommendations (lab studies, medications, referrals, treatment plans, etc.). Education will be done during the visit.
- If labs were ordered at your initial visit, the nurse will contact you in 2 - 4 weeks after the lab results have been received and interpreted by the physician.
- Follow up visits are often necessary and will be determined by the physician.

Medications:

- Please omit **only antihistamines** for three to five days prior to your appointment as they can interfere with allergy testing. See antihistamine list below.
 - Atarax (Hydroxyzine)
 - Azelastine Nasal Spray/Eyedrops (Astelin)
 - Cetirizine (Zyrtec)
 - Chlorpheniramine (Chlortabs)
 - Desloratadine (Clarinex)
 - Olopatadine Nasal Spray/Eye drops (Patanase/Pataday)
 - Diphenhydramine (Benadryl)
 - Dymista Nasal Spray
 - Fexofenadine (Allegra)
 - Levocetirizine (Xyzal)
 - Loratadine (Claritin & Alavert)
 - Zaditor Eye Drops
- **DO NOT** stop any asthma inhalers, steroid nasal spray (Flonase, Nasacort, Nasonex, Rhinocort, Etc.), Montelukast (Singulair), or any non-allergy/asthma medications not listed above. If you have any questions, don't hesitate to contact our office.

Children:

- If the patient is a minor, the adult/guardian accompanying the minor should be the person most familiar with his/her symptoms and history.
- It is best to not bring other children to the clinic on the day of the allergy evaluation. The full attention of a parent is needed to keep a small child occupied during the appointment.
- If two children are to be evaluated on the same day, an adult should accompany each child.

Advanced Allergy & Asthma

Dr. Melissa Graham and Associates



PLEASE COMPLETE IN BLACK INK.

For Office Use Only

MRN _____

DATE _____

HT _____

WT _____

BP _____

HR _____

RR _____

Pulse Ox _____

500 South University • Suite 215 • Little Rock, AR 72205 • Phone 501-420-1085 • Fax 501-420-1457

Patient Name _____

_____ **First** _____ **Middle** _____ **Last** _____

Date of Birth _____ **Sex** M F **Age** _____

Month _____ Date _____ Year _____

How did you hear about our clinic? (Check all that apply.)

Physician (Name: _____) Family/friend (Name: _____)

Internet/Website Yellow Pages Facebook Google

Insurance Directory Television Magazine/Newspaper Ad

Other: _____

List other family members seen by Dr. Graham: _____

Referring Physician _____

Primary Care Physician _____

Other Physician/s you wish to receive office visit letter: _____

CHIEF COMPLAINT

Please explain the **MAIN** reason for your visit. _____

How long have you been experiencing this problem? _____

For Office Use Only. Doctor's Notes:

NASAL/HEAD SYMPTOMS (Check all that apply.) **N/A**

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> itchy eyes | <input type="checkbox"/> sneezing | <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> nasal polyps |
| <input type="checkbox"/> watery eyes | <input type="checkbox"/> posterior nasal drip | <input type="checkbox"/> sore throat | <input type="checkbox"/> throat clearing |
| <input type="checkbox"/> dry eyes | <input type="checkbox"/> snoring | <input type="checkbox"/> itching of throat | <input type="checkbox"/> sinus infections |
| <input type="checkbox"/> dark circles under eyes | <input type="checkbox"/> sleep apnea | <input type="checkbox"/> hoarseness | <input type="checkbox"/> nose bleeds |
| <input type="checkbox"/> itchy nose | <input type="checkbox"/> CPAP | <input type="checkbox"/> sinus pressure | <input type="checkbox"/> headaches |
| <input type="checkbox"/> nasal congestion | <input type="checkbox"/> ear pressure | <input type="checkbox"/> cough | <input type="checkbox"/> loss of taste |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> dizziness | <input type="checkbox"/> roof of mouth itching | <input type="checkbox"/> loss of smell |

At what age did you first experience these symptoms? _____

When do you experience these symptoms? (Check all that apply.)

- Year round Spring Summer Fall Winter

Do these symptoms interfere with daily life? Yes No

Severity of symptoms (Check all that apply.)

- Mild Moderate Severe Worsening Stable

What are the triggers? What makes you worse? (Check all that apply.)

No Known Triggers

Allergens

- grass pollen/cut grass
- hay
- leaves
- house dust
- mold or mildew
- tree pollen
- weed pollen
- dogs
- cats
- other animals: _____

Irritants

- perfumes
- strong scents
- paint
- hair spray
- outside dust
- lying down
- tobacco smoke
- smoke
- while eating

Weather Changes

- cold weather
- temperature changes
- hot humid weather
- rainy/damp weather
- windy days

Have you had previous allergy testing? Yes No Results of Skin Tests: _____

Results of Blood Tests: _____

What physician evaluated you and what year? _____ **N/A**

Have you ever had allergy injections? Yes No If so, how many years? _____ Prescribing physician _____

Are you currently taking injections? Yes No

Did your symptoms improve while on allergy shots? Yes No

Have your symptoms worsened since discontinuing injections? Yes No

HEADACHE SYMPTOMS **N/A**

How long have you had headaches? _____

How often do you get headaches? daily more than 2 times per week less than 2 times per week

How long do they last? _____

What do you do to relieve your symptoms? _____

Location? temple area forehead top of head back of head

Do you have any nausea or vomiting associated with your headaches? Yes No

Are you sensitive to light or sound? Yes No

RECURRENT INFECTIONS **N/A**

Number of ear infections: _____ in the past 12 months _____ total in lifetime

PE tubes: Yes No _____ # of sets

Number of sinus infections _____ in the past 12 months _____ total in lifetime

Number of pneumonias _____ in the past 12 months _____ total in lifetime

Number of antibiotics in the last year _____

Names of antibiotics taken _____

Number of hospitalizations for infections _____ Type of infections _____ Date/s _____

Have you had any lab to check your immune system? Yes Date _____ Lab/location _____ No

Have you had a previous ENT consultation? Yes Date _____ No

Name of ENT doctor _____

Date of last visit _____ Have you had a sinus x-ray? Yes Date _____ No

Have you had a sinus CT? Yes Date _____ No Sinus surgery? Yes No

CHEST SYMPTOMS **N/A**

What are your MAIN chest symptoms? (Check all that apply.)

- cough shortness of breath chest tightness wheezing
- chest congestion recurrent chest infections asthma

What age did these symptoms begin? _____

Was first episode of wheezing with RSV or bronchiolitis? Yes No

Has recurrent bronchitis been a problem? Yes No

How would you describe your symptoms? (Check all that apply.)

- mild moderate severe stable worsening uncontrollable

Triggers- What makes you worse? (Check all that apply.) **No Known Triggers**

- colds or infections exercise/exertion cold air laughing/crying
- morning time nighttime perfumes/strong odors cats
- hot or humid weather lying down stress/anxiety dust pollen

Are your symptoms worsened with seasons? (Check all that apply.)

- spring fall summer winter year round

CHEST SYMPTOMS, cont.

How many days per month is your sleep disturbed by your chest symptoms? _____

How often do your chest symptoms interfere with normal activity? (Check all that apply.)

- NONE minor some limitation extremely limited

How often do you use your rescue inhaler (Albuterol)? (Check all that apply.)

- NONE Less than 2 days/week More than 2 days/week but not daily Daily Several times per day

Have you been to the emergency room for your CHEST symptoms? Yes Date(s)? _____ No

If yes, number of visits in the last 12 months? _____ Number in lifetime? _____

Have you been hospitalized for your CHEST symptoms? Yes No If yes, dates? _____

Number of times in the last 12 months? _____ Number in lifetime? _____ ICU? Intubated?

Have you been treated with an inhaler or breathing machine (updraft)? Yes No

Have you been treated with:

- Oral steroids ____ # in the past 12 months ____ # in lifetime Steroid shots ____ # in the past 12 months ____ # in lifetime

Have you had a chest x-ray? Yes No Date/s _____

Have you seen a pulmonologist? Yes No

If yes, name of physician: _____

SKIN SYMPTOMS/RASH N/A

Have you seen a dermatologist? Yes No If yes, physician? _____ Date _____ Biopsy? Yes No

Describe the appearance. (Check all that apply.)

- red, rough patches itchy red bumps Other? _____

Location? _____ How long has it been present? _____

ECZEMA (Dry, flaky, itchy, sensitive skin) N/A

Severity (Check all that apply.) Mild Moderate Severe Uncontrollable

When did it start? Infancy Childhood As an adult

Soap currently using: _____

Detergent currently using: _____

Lotions currently using: _____

Creams/Ointments used: _____

Is it worsening? Yes No Is it improving? Yes No Does it come and go? Yes No

Are there any known triggers? If so, list below. **No known triggers**

Do foods make it worse? Yes No If yes, list foods: _____

Treatment used: _____

HIVES/SWELLING N/A **(If swelling with no hives, go to the next box.)**

Do you have hive symptoms? Yes No

How long have you had hives? _____ days _____ weeks _____ months _____ years

When do the hives usually occur? early morning immediately after eating evening random middle of the night

How long are your hives present? less than an hour several hours more than 24 hours

Triggers – What makes it worse? (Check all that apply.)

heat cold exercise foods medications pressure unknown

Where do they occur on the body? (Check all that apply.)

face scalp extremities trunk entire body

Do you have any of these symptoms at the time of your hives? (Check all that apply.)

swelling wheezing fainting dizziness throat swelling bruising

vomiting diarrhea fever nausea joint symptoms

What treatments have you used? _____ With relief? Yes No

SWELLING N/A

Have you ever had swelling of the following? (Check all that apply.)

lips tongue face throat hands/arms legs/feet other

Does your swelling occur with hives? Yes No Have you had abdominal pain/cramping with swelling? Yes No

Have you been to the ER or hospitalized in the past year because of hives or swelling? Yes No Date/s: _____

If yes, please explain: _____

Have you taken oral steroids in the past year for hives or swelling? Yes No Steroid shot/s Yes No

Has a physician ordered any blood tests due to hives? Yes or No If so, what doctor? _____

When were the tests ordered? _____

What treatment/s have you used? _____ Relief? Yes No

Is there a family history of swelling? Yes No

INSECT STING REACTIONS (If reacted at the sting site ONLY, do not complete!) N/A

Suspected insect(s) that caused the reaction? _____ Where was the insect? _____

At what age did the reaction occur? _____ # of reactions _____ Body location of stings? _____

How long after the sting did your symptoms occur? _____

Symptoms with reactions: (Check all that apply.)

local swelling shortness of breath wheezing passing out

hives(other than at sting site) feeling of impending doom swelling other than at site

How long did these symptoms last? _____

Treatment _____

ER visits for stings? Yes No # of ER visits _____

Do you have an Epi-Pen? Yes No Have you had an EpiPen? Yes No Have you used an EpiPen? Yes No

Patient Name _____

FOOD REACTIONS **N/A**

Circle the following foods tolerated in current diet: **milk** **egg** **peanut** **tree nuts** **fish** **shellfish** **soy** **wheat**

Please explain, in detail, the suspected food, time after exposure, describe the reaction, any treatment of the reaction, length of the reaction and whether you had to go to the ER or the doctor's office for treatment. _____

Suspected food(s), reaction and symptoms of reaction? Below please explain each reaction separately.

Age/Date	Food	Time after ingestion that symptoms began	Symptoms of reaction	Treatment	Length of reaction	ER/MD Y or N	EpiPen Y or N

How many reactions have occurred? _____

Additional notes regarding reaction/s: _____

REFLUX SYMPTOMS **N/A**

Do you suffer from heartburn or indigestion? Yes No Do you have a history of reflux? Yes No

What medications are you taking to treat your symptoms? _____

What medications have you previously tried? _____

Do you have difficulty swallowing? Yes No Has food gotten stuck in your throat when swallowing? Yes No

Do you clear your throat or cough after eating? Yes No

Have you seen a Gastroenterologist? Yes No

Physician/s Name/s _____

EGD Yes No Date/s/age _____

Swallow Study: Yes No Date/s/age _____

Other Procedure/s _____ Date/s/age _____

Other Procedure/s _____ Date/s/age _____

Other Procedure/s _____ Date/s/age _____

Patient Name _____

DRUG ALLERGIES **No Known Drug Allergies**

List any medications that you are allergic to and the type of reaction you had:

MEDICATIONS **PHARMACY (LOCAL)** _____ **MAIL ORDER** _____

Does your insurance require a 30 day supply of medications? Or a 90 day supply?

Please list all medications including strength and dosage. Include over the counter meds.

ALLERGY or ASTHMA medications CURRENTLY TAKING:

Medication	Strength	Dosage (when and how often)

List any **OTHER** medications **PRESENTLY** taking including the dosage and strength:

Medication	Strength	Dosage (when and how often)

List any **PREVIOUS** allergy or asthma medications tried and the results:

PAST MEDICAL HISTORY (Please check all that apply.) Unknown

<input type="checkbox"/> ADD (Attention Deficit Disorder) <input type="checkbox"/> ADHD (Attention Deficit Hyperactivity Disorder) <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Autism <input type="checkbox"/> Blood clots <input type="checkbox"/> Cataracts <input type="checkbox"/> COPD <input type="checkbox"/> Chronic ear infections <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Diabetes <input type="checkbox"/> Eczema <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Gallstones <input type="checkbox"/> GERD (reflux) <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Lupus <input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Pneumonia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Recurrent bronchitis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> RSV (Respiratory Syncytial Virus) <input type="checkbox"/> Seizures <input type="checkbox"/> Sinus infections, chronic or recurrent <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Tuberculosis
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Cancer Yes No **Type** _____ **Year** _____

Treatment: Chemotherapy Radiation Surgery

Illnesses not listed: _____

HOSPITALIZATIONS

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

ALLERGIC FAMILY HISTORY (Please check IMMEDIATE family who have a history of the following.) Unknown

Asthma: Mother Father Sister Brother Daughter Son **Allergic rhinitis:** Mother Father Sister Brother Daughter Son

Sinus problems: Mother Father Sister Brother Daughter Son **Nasal polyps:** Mother Father Sister Brother Daughter Son

Eczema: Mother Father Sister Brother Daughter Son **Hives:** Mother Father Sister Brother Daughter Son

Food allergy: Mother Father Sister Brother Daughter Son

GENERAL FAMILY HISTORY – In your generation or the generation before you, are there any of the following? (Check all that apply.)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Migraine	<input type="checkbox"/> Lupus
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Tuberculosis

Other illnesses not listed: _____ Unknown

SURGICAL HISTORY Unknown

Tonsillectomy Yes Date _____

Adenoidectomy Yes Date _____

PE tubes Yes _____ Date(s) _____ Number of sets _____

Polypectomy (nasal polyp removal) Yes Date _____ Septoplasty (nasal bone repair) Yes Date _____

Sinus Surgery Yes _____ Date _____ Type: _____

Other Surgeries _____

PEDIATRIC HISTORY (For patients 0-12 years of age)

Unknown

Birth weight: _____ lbs _____ oz

Was birth premature? Yes No If yes, how many weeks **early**? _____ No

RSV before 3 months of age? Yes No

Reflux as an infant? Yes No

Multiple formula changes? Yes No

SOCIAL HISTORY

City of residence _____ Hometown _____

Most recent occupation _____

Types of work done in past _____

Workplace Exposures - Please list. _____

If a child, grade in school: _____

ENVIRONMENTAL REVIEW (Check all that apply.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Apartment | <input type="checkbox"/> Birds | <input type="checkbox"/> Carpet in bedroom |
| <input type="checkbox"/> House | <input type="checkbox"/> Cat indoors | <input type="checkbox"/> No carpet in home |
| <input type="checkbox"/> Mobile home | <input type="checkbox"/> Cat outdoors | <input type="checkbox"/> Feather pillow |
| <input type="checkbox"/> Gas/Propane Heat | <input type="checkbox"/> Dog indoors | <input type="checkbox"/> Cotton pillow |
| <input type="checkbox"/> Electric heat | <input type="checkbox"/> Dog outdoors | <input type="checkbox"/> Zipper encasing |
| <input type="checkbox"/> Space heater | <input type="checkbox"/> No pets | <input type="checkbox"/> Cotton mattress |
| <input type="checkbox"/> Wood burning fireplace | <input type="checkbox"/> Other animals | <input type="checkbox"/> Feather mattress/topper |
| <input type="checkbox"/> Central air conditioning | List: _____ | <input type="checkbox"/> Tobacco/Smoke Exposure/How often? _____ |
| <input type="checkbox"/> Window air conditioner | _____ | <input type="checkbox"/> Family members smoke indoors |
| | | <input type="checkbox"/> Family members smoke outdoors |

SMOKING STATUS

_____ Smoker _____ Non-smoker Are you exposed to tobacco smoke? Yes No

Current every day smoker/Age started: _____/How many per day? _____

Former smoker/ Age quit: _____ How long did you smoke? _____

How many packs per day? _____

Do you use recreational drugs? Yes No If so, which ones? _____

Check the tobacco type used.

- Cigarettes
- Cigars
- Pipe
- Chewing tobacco
- Snuff

Do you use alcohol? Yes No If yes, how much and how often? _____

IMMUNIZATION HISTORY

Are your immunizations up to date? Yes No

Did you receive your flu vaccine this year? Yes No If yes, when? _____

Have you received a pneumonia vaccine? Yes No If yes, when? _____

Have you received a tetanus booster in the last 10 years? Yes No

REVIEW OF SYSTEMS (Check the symptoms that you are currently experiencing.)

N/A

GENERAL

- Fever
- Night sweats
- Weight loss

SKIN

- Dry skin
- Rash
- Itching
- Hives

HEENT

- Dry eyes
- Itchy eyes
- Watery eyes
- Glaucoma
- Glasses/Contacts
- Good vision
- Nasal drainage
- Nasal congestion
- Nasal polyps
- Sinus pressure
- Sinus pain
- Runny nose
- Sneezing
- Headache
- Ear infection
- Earache
- Ringing in ears
- Vertigo
- Hoarseness
- Sore throat
- Oral ulcers
- Snoring
- Sleep apnea
- CPAP

RESPIRATORY

- Cough
- Shortness of breath
- Sputum production
- Wheezing
- Decreased exercise tolerance

CARDIOVASCULAR

- Chest pain
- Swelling of extremities
- Difficulty breathing lying down
- Irregular heartbeat

GASTROINTESTINAL

- Heartburn
- Indigestion
- Nausea
- Vomiting
- Abdominal pain
- Difficulty swallowing
- Bloody stools

NECK

- Neck mass
- Swollen glands

MUSCULOSKELETAL

- Joint swelling
- Joint pain
- Muscle weakness

NEUROLOGICAL

- Stroke
- Tremor
- Dizziness

PSYCHIATRIC

- Confusion
- Anxiety
- Depression

ENDOCRINE

- Excessive thirst
- Excessive urination
- Thyroid problems

HEMATOLOGY

- Anemia
- Nose bleeds
- Easy bruising

For Office Use Only

Reviewed by physician:

D. Melissa Graham, M. D.

Date