Creve Coeur
711 Old Ballas Road, Suite 100·St. Louis, MO 63141
Phone: 314-569-0510·Fax: 314-569-1085
O'Fallon
9963 Winghaven Blvd, O'Fallon MO 63368
Phone: 636-265-2886·Fax: 636-265-2908

Dear _____,

Your appointment is scheduled for _____ at _____ O'clock.

We thank you for choosing Allergy and Asthma Consultants! We hope to get you feeling better soon.

Please complete the attached forms and bring to your appointment along with your insurance card and photo ID. If a referral is needed, please have your PCP fax it to us prior to your appointment.

Initial office visits last about two hours. Please arrive 15 minutes before your appointment to complete the check in process.

If you have any questions, please contact our office.

Thank you and we look forward to seeing you soon!

Sincerely,

Robert F. Onder, M.D.

Jaclyn Hey, NP

Allergy & Asthma CONSULTANTS

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Please stop all antihistamines before your visit.

The following medications should be stopped **5 days prior** to your appointment:

Zyrtec (cetirizine)

Xyzal (levocetirizine)

Claritin/Alavert (loratadine)

Allegra (fexofenadine)

The following medications should be stopped **3 days prior** to your appointment:

Benadryl (diphenhydramine)

Pepcid (famotidine)

Tagamet (cimetidine)

Zantac (Ranitidine)

OTC cold medications

The following medications should be stopped **1 day prior** to your appointment:

Allergy eye drops (Pataday, Zaditor, etc)

Allergy antihistamine nasal sprays (Astelin, Azelastine, Patanase)

Singulair (montelukast)

Please note:

*Inhalers for asthma and nasal steroid sprays (Flonase, Nasacort, etc.) do not need to be stopped prior to your appointment.

*If you are unable to stop your medications, inform staff once you arrive for your appointment.

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Patient information Form

Patients Name: _____
Last First M.I.

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

DOB:_____ Sex: ☐ Male ☐ Female SSN:_____

Email address:_____Marital status: Single Married Widowed Divorced

Race: Asian Black/African American Indian Township Mexican American Indian White

Primary Care Provider_____ Phone Number_____

Family members who are patients here:_____

Pharmacy:_____Location:_____Phone number:_____

Emergency Contact:_____Relation:_____Phone Number:_____

If patient is a minor please complete this section

Mother's name: _____ DOB:_____
Last First

Home Phone:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Email address:_____

Father's name: _____ DOB:_____
Last First

Home Phone:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

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Insurance information

Primary Insurance: _____ ID#: _____ Group#: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Secondary Insurance: _____ ID#: _____Group#_____

Policy Holder Name:_____Relationship to Patient:_____

Policy Holder DOB: _____ Policy Holder SSN: _____

Responsible Party Information:

Name of person responsible for account:_____DOB:_____

Phone number: _____ Relation to patient: _____

Consent

I give Allergy and Asthma Consultants, P.C. permission to disclose my medical information to:

Family members name: _____Relation: _____

I hereby, assign payment of authorization medical benefits to include major medical benefits to which I am entitle; to be made on my behalf to Allergy and Asthma Consultants, P.C. for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges weather or not paid by said insurance.

Allergy and Asthma Consultants, P.C. does not deny any benefits or services because of race, color, national origin, age, gender, disability, religious or political beliefs. If you feel that have been discriminated against, you may file a Complaint of Discrimination with the manager of this facility. You will not suffer any penalty because you file a complaint.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court cost), in the event that I would fail to pay my bill.

Date: _____ Signature:_____

Patient (over 18 years) or responsible party

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New Patient History

Patient's Name:_____DOB:_____
Last *First* *Middle*

Primary Care Provider_____ Phone Number_____

How did you hear about our office?

☐ Referred by physician: (name)_____ ☐ Advertisement

☐ Referred by family or friend ☐ Internet

☐ Facebook ☐ Other:_____

What is your chief complaint/ Why did you schedule appointment?

_____

Please circle Yes or No

Symptoms:

Cough?	Yes / No
Wheeze?	Yes / No
Tight Chest?	Yes / No
Fatigue?	Yes / No
Shortness of breath	Yes / No

Eye Symptoms:

Itching?	Yes / No
Watering?	Yes / No
Redness?	Yes / No
Puffiness?	Yes / No

Nasal symptoms:

Nasal Drainage?	Yes / No
Sneezing?	Yes / No
Stuffy nose?	Yes / No
Mouth Breathing?	Yes / No
Itch of the roof of your mouth?	Yes / No
Snoring?	Yes / No
Sinus Headache	Yes / No

Ear Symptoms:

Itching?	Yes / No
Infections?	Yes / No

Skin Symptoms:

Hives?	Yes / No
Rashes?	Yes / No
Eczema?	Yes / No

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Have you had sinus infections? Yes / No
*If yes, how often?*_____

Do symptoms awaken you at night? Yes / No
*If yes, which symptoms and how often?*_____

Are you limited in your daily activities? Yes / No

Do you miss days of work/school because of your illness? Yes / No
*How many in the last year?*_____

Have you gone to the emergency room because of asthma /allergy episodes? Yes / No

Have you ever had a life-threatening reaction to?
Foods Yes / No
Insect stings (bee, wasp) Yes / No
Rubber/latex Yes / No

Medical/Allergy Testing
Have you ever had:

Chest X-Ray: Yes / No
If yes, date of most recent X-Ray:_____*Where was test done*?_____
*Results:*_____

Sinus X-Ray or CAT Scan of sinuses? Yes / No
*If yes, date?*_____*Where was test done?*_____
Results:_____

Allergy Testing? Yes / No
*If yes, date of most recent test:*_____*Where was test done?*_____
Results:_____

Have you ever taken allergy shots? Yes / No
*If yes, how long?*_____ *When?*_____

Pulmonary Function Testing? Yes / No
If yes, date of most recent test:_____*Where was test done?*_____
Results:_____

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List All of your current medications, including over-the-counter medications:

Medication	***Dose***	***How Often***

Do you have any medication Allergies, if yes please list? Yes / No _____

_____

Have you ever taken prednisone, cortisone, or other steroids (by mouth)? Yes / No

Smoking/Alcohol

Do you currently smoke? Yes / No
Have you smoked in the past? Yes / No
*If yes, for how many years?*_____ *How much a day?*_____*When did you quit?*_____
Does anyone in your home smoke? Yes / No
Do you drink alcoholic beverages? Yes/ No
If yes, how many drinks per day/week: _____

Animals/Pets: Yes / No

*What kind of pets and how many?*_____

*How long have you had the animal(s):*_____

Caffeine/ Exercise/ Occupation:

Do you drink caffeine? Yes/No How often? _____

Do you exercise? Yes/No How often? _____

Occupation: _____

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Medical History

Have you ever had:

Bronchitis:	Yes / No	Blood disease:	Yes / No
Pneumonia:	Yes / No	Anemia:	Yes / No
Emphysema:	Yes / No	Osteoporosis:	Yes / No
Exposure to tuberculosis:	Yes / No	Seizures:	Yes / No
Positive TB skin test:	Yes / No	Stomach problems:	Yes / No
Other lung disease:	Yes / No	Have you ever needed oxygen:	Yes / No
Heart Problems:	Yes / No	High blood pressure:	Yes / No
Heart Attack:	Yes / No	High Cholesterol:	Yes / No
Diabetes:	Yes / No	Kidney disease:	Yes / No
Liver disease:	Yes / No		

Have you ever been hospitalized: Yes / No

If yes, give reason and dates:

Reason for Hospitalization:	***Dates:***

Have you ever had surgery: Yes / No?

If so, give reasons/procedures, dates:

Reasons:	***Procedure/s:***	***Dates:***

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Review of Systems

Do you currently have?

Constitutional
Fatigue: Yes / No
Fever: Yes / No

Dermatology
Hives: Yes / No
Rash: Yes / No
Dry or sensitive skin: Yes / No

Ophthalmology
Blurring of Vision: Yes / No
Diminished Vision: Yes / No
Vision Loss: Yes / No

Urology
ENT
Loss of Smell: Yes / No
Hearing Loss: Yes / No
Ringing in Ears: Yes / No

Endocrinology
Cold/Heat intolerance: Yes / No
Excessive thirst: Yes / No
Increased urination: Yes / No

Cardiology
Chest Pain: Yes / No
Dizziness: Yes / No
Palpitations: Yes / No

Gastroenterology
Abdominal pain: Yes / No
Difficulty swallowing: Yes / No
Heartburn: Yes / No
Nausea/Vomiting: Yes / No

Hematology/Lymph
Loss of appetite: Yes / No
Swollen glands: Yes / No

Musculoskeletal
Joint pain/stiffness/swelling: Yes / No
Sciatica: Yes / No

Difficulty urinating: Yes / No
Frequent urination at night: Yes / No

Neurology
Memory Loss: Yes / No
Seizures: Yes / No

Psychology
Anxiety: Yes / No
Depression: Yes / No
Sleep disturbances: Yes / No

Pediatric Patients Only

Length of pregnancy? _____ Months

Were there problems during pregnancy, delivery, or newborn period? Yes / No

If yes, please explain: _____

Birth weight? _____ Lbs. _____Oz.

Has your child had chicken pox? Yes / No
Has your child had RSV? Yes / No
Are your child's immunizations up to date? Yes / No

Research Studies

Dr. Onder and Allergy and Asthma Consultants, P.C. conduct clinical research studies on new allergy and asthma medications.
Would you or your child be interested in participating in a medication study? Yes / No