Allergy & Asthma Specialty Services, P. S.

T. Ted Song, D.O. Kristi McKinney, M.D. Jennifer Cole, D.O. Kelly Dart, ARNP Jamie Baylor, ARNP

Office Addresses & Shot Hours

Lakewood Office: 11203 Bridgeport Way S.W.
Lakewood, WA 98499
Phone: (253)589-1380
Monday & Tuesday 7:30am-11:30am/1:00-4:30pm
Thursday 7:30am-11:30am/1:00-5:00pm
Saturday 7:30am-11:30am

Puyallup Office: 318 39th Ave S.W., Suite B
Puyallup, WA 98373
Phone: (253)589-1380
Monday & Tuesday 7:30am-11:30am/1:00 - 4:30pm
Thursday 7:30am-11:30am/1:00-5:00pm

Gig Harbor Office: 4700 Point Fosdick Dr. NW, Suite 310
Gig Harbor, WA 98335
Phone: (253)589-1380
Monday &Tuesday 7:30am-11:30am/1:00pm-4:30pm
Thursday 7:30am-11:30am/1:00-5:00pm

Olympia Office: 205 Lilly Rd NE Unit A-1
Olympia, WA 98502
Phone: (253)589-1380
Monday & Tuesday 7:30am-11:30pm/1:00pm-4:30pm
Thursday 7:30am-11:30am/1:00-5:00pm

Silverdale Office: 9657 Levin Road NW, Suite 250
Silverdale, WA 98383
Phone: (253)589-1380
Monday, Wednesday, and Thursday 7:30am-11:30am/1:00pm-4:30pm

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Pulse: _____ **Nurse:** _____
Resp: _____ **Wgt:**_____
O2: _____ **Last AH date:** _____
BP: _____ **AH name:** _____
CIU Score: _____

ALLERGY WORKSHEET

NAME:	**AGE:**	**BIRTHDATE:**	**DATE:**
HOME ADDRESS:	**PHONE:**		

HISTORY: **(for physician only)**

Pulm Function Test: **Yes** **No**
1:_____
2:_____
3:_____
4:_____
5:_____

Total: _____

Have you ever been hospitalized or visited an Emergency Room for your symptoms? **Yes** **No**
When?

Do you notice any association between symptoms and any Foods, Medications, or anything you apply to your body? **(If yes, please list)**

CHECK YOUR MAIN SYMPTOMS BELOW:

□ blocked nose	□ bad breath	□ red eyes	□ skin rash	□ chest pain
□ itchy nose	□ post nasal drip	□ itchy eyes	□ faintness	□ palpitations (heart flutter)
□ runny nose	□ facial pain	□ watery eyes	□ unconsciousness	□ diarrhea
□ sneezing	□ blocked ears	□ headache	□ shortness of breath	□ stomach pain
□ poor sense of smell	□ itchy ears	□ frequent colds	□ wheezing	□ stomach cramp
	□ eczema	□ swelling	□ chronic cough	□ others
□ discolored nasal mucus	□ itching	□ hives	□ night cough	
	□ welts	□ tightness of the chest		

When did symptoms first appear?	**What time of year is worse?(Which months):**

Check those factors below which cause or increase your symptoms:

□Air conditioning	□Dust, indoors	□Flowers, trees	□Paint, varnish	□Tobacco smoke
□Air pollution	□Dust, outdoors	□Grasses, weeds	□Pets, other animals	□Winds, drafts
□Aspirin	□Exertion	□Industrial fumes	□Pregnancy	□Worry, tension
□Bright lights	□Fabrics	□Insecticides	□Rain, dampness	□Sun
□Colds, flu	□Feathers	□Menses	□Soaps, detergents	□Vibration
□Cosmetics, perfumes	□Fireplace smoke	□Newsprint	□Temperature change	□Other
□Heat				

ALLERGY WORKSHEET (Con't)

NAME:	AGE:	BIRTHDATE:	DATE:

Have you had allergy tests before?
□ YES □ NO If yes, where was the testing done?

Have you taken allergy shots? **Did Shots Help?**
□ YES □ NO If yes, number of years? _____ Year Stopped____ YES □ NO □

Do you have a food allergy? □ YES □ NO If yes, which foods?

Do you have a drug allergy? □ YES □ NO If yes, which drugs?

Do you have an allergy to insects? □ YES □ NO If yes, which insects?

Is there any family history of?
Allergies? □ Yes □ No Who?
Asthma? □ Yes □ No Who?
Eczema? □ Yes □ No Who?

Do you have any of the following symptoms? (check any that apply)

□ Fever
□ Problems with your digestive system
□ Problems with your urinary tract
□ Weight Loss
□ Other:
□ Problems with your skin
□ Problems with your bones or joints
□ Problems with your heart
□ Problems with your nervous system
□ Problems with your blood
□ Dental problems
□ "Heartburn"
□ Swollen lymph nodes or other masses

Check any diseases or surgeries you may have had:

□sinus surgery	□tonsillectomy	□migraine	□tuberculosis	□hiatus hernia	□seizure/epilepsy
□sinus infection	□adenoidectomy	□kidney disease	□heart disease	□pneumonia	□bronchitis
□nasal polyp removal	□ear surgery	□hypertension	□glaucoma	□liver disease	□hysterectomy
□nose surgery	□arthritis	□cancer	□diabetes	□appendectomy	

List any other medical diagnosis or surgeries:

How long have you lived in Washington State? _____

Where did you grow up? _____Where did you live before Washington State? _____

Do you smoke? □ Yes □ No
If yes, how much? _____
If you have quit smoking,
How many years did you smoke?
Do others smoke at home? □ Yes □ No
When did you quit?

Do you have pets? □ Yes □ No
Are they indoor or outdoor pets?
List type of pets:

Where do pets sleep? _____

What is your occupation?

Work location? Indoors Outdoors

Home Location
□Rural □Near Freeway
□Suburbs □Near Farming
□Near Industry □Urban

Home Heating System:
□Gas □Electric □In wall heaters
□Baseboard □Forced Air
□Radiant Heat □Woodstove
□Fireplace □Heat Pump
□Oil □Radiant

Bedroom
□Carpeting □Indoor plants
□Feather bedding
Mattress Type
□Innerspring □Foam
□Waterbed □Futon

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Current List Of Medications

Name: _____ Birthday: _____

Pharmacy: _____

Please note that it is important for the Allergist to know your current medications you are taking and the date you started to take them. This way the Allergist can check if there are any drug interactions.

#	Name of Medication	Strength	How Often Taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

ALLERGY AND ASTHMA SPECIALTY SERVICE, P.S.

Common Medications to Avoid Prior to Testing

1. Prescription Antihistamines – *DO NOT TAKE 72 HOURS PRIOR TO TESTING*

Bomfed Capsules Brohist	Chol Tuss Histex (triprolidine)	Meclizine (Antivert) NoHist	Periactin (cyproheptadine)	Tavist-(Clemestine) Phenergan	

2. Over the Counter Antihistamines – *DO NOT TAKE 72 HOURS PRIOR TO TESTING*

Alka-Seltzer Cold Alka-Seltzer Flu Alka-Seltzer Night Alka-Seltzer PLUS Alka-Seltzer Sinus	Aller-Chlor Allerest Aprodine Benadryl (Diphenhydramine)	Chlor-Trimeton Chlorpheniramine Coridcidin Cold/flu Dimetapp Excedrin PM	Nyquil Pedia-Care Allergy Pediatric Cough & Cold Sudafed Cold & Allergy Tavist D	Thera-Flu Thera-Flu Cold Thera-Flu Sinus Triaminic Triaminic night cold	Tylenol Cold Tylenol Flu Tylenol PM ***All Sleep Aides***

3. Antihistamines – *DO NOT TAKE 7 DAYS PRIOR TO TESTING*

Allegra (Fexofenadine) Atarax,Vistaril (Hydroxyzine) Clarinex (Desloratadine)	Claritin (Loratadine) RyVent (Karbinal)	Xyzal (Levocetirizine) Zyrtec (Cetirizine)

4. Nasal Sprays with Antihistamines – *DO NOT TAKE 48 HOURS PRIOR TO TESTING*

Astelin (Azelastine)	Astepro	Patanase (Olopatadine)

5. Eye Drops with Antihistamines – *DO NOT TAKE 72 HOURS PRIOR TO TESTING*

Any over the counter allergy eye drops that may contain antihistamines.

Azelastine Elestat (Epinastine) Naphcon-A	Opcon A Pataday (Olopatadine) Patanol	Pazeo Visine-A Zaditor (ketotifen)

6. Anti-Itch Creams – *DO NOT Use on forearms/back 24 HOURS PRIOR TO TESTING*

Betamethasone Clobetasol	Cortaid (Hydrocortisone) Mometasone	Triamcinolone

7. Muscle Relaxers – *DO NOT TAKE 72 HOURS PRIOR TO TESTING*

Flexeril (cyclobenzaprine)

8. Antidepressants & Tranquilizers – *IF POSSIBLE DO NOT TAKE 72 HOURS PRIOR TO TESTING*

Always ask your doctor prior to stopping any antidepressants or tranquilizers.

Abilify Amitriptyline	Silenor (doxepin) Marplan	Nardil Norpramin	Pamelor (Nortriptyline) Parnate	Risperdal Seroquel	Surmontil

9. Antidepressants & Tranquilizers – *IF POSSIBLE DO NOT TAKE 10 DAYS PRIOR TO TESTING*

Always ask your doctor prior to stopping any antidepressants or tranquilizers.

Remeron (Mirtazapine)

10. H2 blockers (also sometimes referred to as aid reducers or H2 receptor antagonists) are available in nonprescription and prescription forms. IF POSSIBLE DO NOT TAKE 3 DAYS PRIOR TO TESTING.

Axid (Nizatidine)	Pepcid/Zantac 360 (famotidine)	Tagamet (cimetidine)

Note: **It is impossible to have a complete list of antihistamines. Antihistamines affect how patients respond to allergy testing. Always review your medications to see if they contain antihistamines.**
For HIVE patients, do NOT hold antihistamines without discussing with the provider first.
Do NOT stop asthma inhalers.
You may take Singulair (montelukast), nasal steroids, Sudafed (pseudoephedrine).
*** If you have any questions about your medication. Do not hesitate to give us a call at 253-589-1380 ext #2.**

General Patient Information

_____ _____ _____ Please circle one:

Last Name **First Name** **MI** **SEX: M F**

_____

Mailing Address

_____

City **State** **Zip**

Patients Age: _____ Date of Birth: _____
Month/ Day/ Year

Employer: _____

Race: **Please circle one**

Decline Caucasian African American Hispanic Asian

Native American Pacific Islander Other: _____

Ethnicity: **Please circle one**

Decline Hispanic or Latino Non- Hispanic or Latino Unknown

Best Daytime Phone #: Please circle one:
(_____) _____-_____ (Mobile, Home or Work)

Check one: Self Spouse Parent Other: _____

Alternate Phone #: Please circle one:
(_____) _____-_____ (Mobile, Home or Work)

Check one: Self Spouse Parent Other: _____

Email Address: _____

Emergency Contact:

_____
Name Phone # Relation to Patient

1. **Do you have other family members who are seen by our providers? If so, list name(s) & their relationship to patient.**
   Please Circle one: No Yes : _____
2. **Were you referred to us by a healthcare provider?**
   Please Circle one: No Yes : _____
3. **Would you like you visit sent to your primary care provider? Please state title, such as: MD, ARNP, DO , ND**
   Please Circle one: No Yes : _____
4. **Artificial Intelligence (AI) and other technology can be used to efficiently gather data to aid in the creation and management of the electronic medical record. I hereby consent to the use of AI scribe dictation technology in the documentation of my medical records. You may verbally opt-out of this use at the time of care. The opt-out will be documented by your provider.** Please Circle one: No Yes

Insurance Information

Primary Insurance Company Name: _____

ID/ Member #:_____ Insurance Address: _____
Street City/ State Zip

Group or Local #: _____

Subscriber's Name: _____ Employer of Subscriber: _____
(As it appears on insurance card) Please Circle one:

Subscriber's Date of Birth: _____ Subscriber's Relationship to patient: Self Spouse Other: _____

Secondary Insurance: NO YES: _____

ID/ Member #:_____ Insurance Address: _____
Street City/ State Zip

Group or Local #: _____

Subscriber's Name: _____ Employer of Subscriber: _____
(As it appears on insurance card) Please Circle one:

Subscriber's Date of Birth: _____ Subscriber's Relationship to patient: Self Spouse Other: _____

Assignment of Insurance Benefits/ Consent to Care

I authorize and request my insurance company to pay directly to the doctor the amount(s) billed on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover entire medical and surgical expense, I will be responsible for payment of the difference: and if the nature of the disability be such that it is not covered by the policy I will be responsible to the doctor for payment of the entire bill.

Patient or Guarantor's signature: _____ **Date**: _____
Please Circle one:

Print Name of Signature Above: _____ **Relationship to Patient**: Self Parent/ Legal Guardian Other: _____

ALLERGY AND ASTHMA
SPECIALTY SERVICE, P.S.

Paperwork for New Patients

Last Name:		First Name:		MI:		BD:	
Appt w/Allergist				Office			
Appt Date:		Appt Time:					
Name of Receptionist Preparing Paperwork:				Date Mailed:			

Welcome to our office! Below you will find some information that will be helpful for you.

Be aware that we will not know if the doctor will be ordering any tests on your first visit. (Check the list of medications you need to avoid that is included in this packet). The doctor will make the decision after evaluating your medical problem. In case you are tested you need to be prepared with the following:

- Please wear a loose, short-sleeved shirt so the nurse can access your arms for testing.
- Testing appointments usually run about 2 ½ hours.

Please fill out the forms that are included in this packet and bring them to your first appointment.

- Please arrive 15 minutes prior to your appointment time so that the receptionist can go over the paperwork and get you checked in.
- Please refrain from using any fragrance or fragrant lotions as they can cause allergy or asthma symptoms to patients and staff. Do wear comfortable clothing.
- We recommend you do not bring small children to your testing appointment as it may be difficult for them due to the length of the testing process.
- Please bring all your medical insurance cards and photo ID to your first appointment.
- Copays are an agreement between you and your medical insurance and they need to be paid at the time of service. Please come prepared to pay this at your visit with us or there will be a $10 service fee added on to the copay amount.
- HMO plan patients: You need to bring your HMO card to the first office visit or allergy shot of each month.

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CONSENT TO DISCUSS MEDICAL CARE

Patient Name: (please print) _____ Date of birth: _____

I authorize Allergy & Asthma Specialty Service (AASS) to discuss my medical information with the following individuals I have listed below. Please print all names. You do **NOT** need to list physicians.

Name	Date of birth	Relationship
Name	Date of birth	Relationship
Name	Date of birth	Relationship
Name	Date of birth	Relationship

I give my permission for AASS to leave detailed medical information at my telephone number(s):

☐ ( ) _____-_____ ( ) _____-_____

☐ Or, I do not want detailed medical information left on any of my phone numbers.

_____ _____
(Signature of patient, parent or legal guardian) Date

_____
Printed name of signature above

CONSENT FOR TREATMENT OF A MINOR

Date: _____

I, _____, the parent/legal guardian of _____,
Please print your name **Please print patient's name**

_____ authorize and consent to routine and medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right of prior informed consent to such treatment. **This authorization shall remain effective unless revoked in writing by me.**

Signature of parent/guardian **Date signed**

- **NOTE: For your child's safety, AASS requires all children under the age of 16 to be accompanied by an adult (18years or older) for the duration of their visit when receiving allergy shots or being seen by the physician.**