



Allergy & Asthma Care, Inc.

John Seyerle, MD and Ashish Mathur, MD

Board Certified, Allergy and Immunology

Specializing in Adult and Pediatric Allergies and Asthma

You have an appointment at Allergy & Asthma Care at the following address:

**Springdale Office
422 Ray Norrish Dr.
Cincinnati, Ohio 45246
513.671.6707
513.671.6710**

You can visit our website at www.allergy-asthmacare.com Please call 513.671.6707 with any questions or concerns.

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR VISIT

Name: _____
DOB: _____
Primary Care Doctor: _____
Referred by: _____

Welcome. What brings you to see us today? _____

When did you take your last antihistamine? _____

1. ALLERGY / SINUS - Age first noticed _____

Symptoms - check all that apply

<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	Sinus infections	<input type="checkbox"/>	Ears plugged up	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Congestion	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	Itchy eyes	<input type="checkbox"/>	Chest tightness
<input type="checkbox"/>	Itchy nose	<input type="checkbox"/>	Change in taste or smell	<input type="checkbox"/>	Watery eyes	<input type="checkbox"/>	Exercise intolerance
<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	

List treatments that have helped _____

Treatments that have not helped _____

Triggers - check all that apply

<input type="checkbox"/>	Spring	<input type="checkbox"/>	Cut grass	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Cleaning agents/bleach
<input type="checkbox"/>	Summer	<input type="checkbox"/>	Raking leaves	<input type="checkbox"/>	Laughter	<input type="checkbox"/>	Cigarette smoke
<input type="checkbox"/>	Fall	<input type="checkbox"/>	Other outdoor	<input type="checkbox"/>	Stress	<input type="checkbox"/>	Perfumes and odors
<input type="checkbox"/>	Winter	<input type="checkbox"/>	Moldy places	<input type="checkbox"/>	Menstruation	<input type="checkbox"/>	Foods
<input type="checkbox"/>	Year round	<input type="checkbox"/>	Dust	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Medications
<input type="checkbox"/>	Weather changes	<input type="checkbox"/>	Animals/pets	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Colds/viruses

2. ASTHMA - Age at first diagnosis _____

Symptoms - check all that apply

<input type="checkbox"/>	Cough	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Throat tightness
<input type="checkbox"/>	Wheeze	<input type="checkbox"/>	Chest tightness	<input type="checkbox"/>	Chest burning
<input type="checkbox"/>	Mucous	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Other

Number of asthma hospital admissions ever: _____ In the last 12 months: _____
Number of asthma ICU admissions ever: _____ In the last 12 months: _____
Number of courses of oral steroids for asthma ever: _____ In the last 12 months: _____

(in the past 4 weeks)

Is your asthma well controlled? Y / N
Have you limited your activity due to your asthma? Y / N
Missed work due to your asthma? Y / N
Woken up at night coughing or shortness of breath? Y / N
Maximum number of albuterol puffs in one day: _____
of days using any albuterol in last month: _____

List treatments that have helped _____

Treatments that have not helped _____

3. ECZEMA - Age first noticed _____ Frequency: _____

Describe the rash: _____

List any triggers: _____

List treatments that have helped: _____

Treatments that have not helped: _____

4. HIVES - Age first noticed _____ Frequency: _____

Describe the rash: _____

List any triggers: _____

List treatments that have helped: _____

Treatments that have not helped: _____

5. FOOD ALLERGIES - describe below

Food	Age	Describe Reaction and Treatment

What foods are you currently avoiding? _____

6. INSECT STING REACTIONS - describe below

Insect	Age	Describe Reaction and Treatment

7. CURRENT MEDICATIONS: please attach list or list all

8. MEDICATION AND LATEX ALLERGIES - please list all previous reactions to medications

Medication	Age	Describe Reaction

9. OTHER MEDICAL HISTORY - check all that apply

<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Diabetes/sugar	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	Other
<input type="checkbox"/>	Reflux/heartburn	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Hepatitis or HIV	<input type="checkbox"/>	

Please list all Surgeries and other medical problems: _____

Infections - Number in lifetime, if more than zero, please describe and give dates

<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Fungal infections	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Skin infections	<input type="checkbox"/>	Ear infections
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Sepsis	<input type="checkbox"/>	Other

Immunizations - Up to Date? Y / N (explain) _____

Reactions to immunizations, if any _____

Last Tetanus: _____ Flu: _____ Pneumonia: _____

10. FAMILY HISTORY - if yes, please state who

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Cystic Fibrosis
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	Immune Deficiencies	<input type="checkbox"/>	Other

11. ENVIRONMENTAL HISTORY - Check all that apply

<input type="checkbox"/>	House	<input type="checkbox"/>	Basement	<input type="checkbox"/>	Carpeting	<input type="checkbox"/>	Carpet in Bedroom
<input type="checkbox"/>	Townhouse	<input type="checkbox"/>	Mold or moisture	<input type="checkbox"/>	Wood Floors	<input type="checkbox"/>	Feather/down bedding
<input type="checkbox"/>	Apartment	<input type="checkbox"/>	Gas Heat	<input type="checkbox"/>	Cats, #	<input type="checkbox"/>	Feather/down pillows
<input type="checkbox"/>	Condo	<input type="checkbox"/>	Electric Heat	<input type="checkbox"/>	Dogs, #	<input type="checkbox"/>	Dust mite covers
<input type="checkbox"/>	Mobile home	<input type="checkbox"/>	Central Air	<input type="checkbox"/>	Birds, #	<input type="checkbox"/>	Tobacco Smoke
<input type="checkbox"/>	City	<input type="checkbox"/>	Window A/C	<input type="checkbox"/>	Other Animals	<input type="checkbox"/>	Other exposures
<input type="checkbox"/>	Suburb	<input type="checkbox"/>	Wood stove/fireplace	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Rural	<input type="checkbox"/>	Propane heat	<input type="checkbox"/>		<input type="checkbox"/>	

What is your occupation? _____

Who else lives in your home? _____

Are there any other exposures that you are concerned about? _____

Smoking?

<input type="checkbox"/>	Current	Age first started -	Below list any household members that smoke
<input type="checkbox"/>	Quit	Ages last quit -	
<input type="checkbox"/>	Never	Average packs per day -	

12. OTHER SYMPTOMS - check all symptoms that you have currently

<input type="checkbox"/>	Fever	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Vision changes
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Muscle aches	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Burning	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Anxiety

ALLERGY & ASTHMA CARE, INC.

John Seyerle, M.D.

Ashish Mathur, M.D.

Please Print

Patients Name _____ D.O.B. _____

E-mail Address _____

Because we value your right to privacy, we would like to determine how to best handle our telephone communications with you. We routinely call our patients for the following reasons:

1. To Confirm Appointments
2. With Test Results
3. To Respond To Your Questions or Concerns

In the event we attempt to contact you and you are not available, what would you like us to do?
Leave a message on your answering machine/voice mail

Home Phone Number _____ Cell Phone Number _____

____ Leave the information with:

Last Name: _____

First Name: _____

Relationship: _____

Telephone #: _____

Last Name: _____

First Name: _____

Relationship: _____

Telephone#: _____

____ Do Not leave information about me on an answering machine/voice mail or with another person. Leave a name and telephone number and I will return your call.

By signing this form you are letting us know the best way to provide you with your personal health information by phone. If any of this information changes, you are responsible for notifying us, preferably in writing.

Signature: _____ Date: _____

ALLERGY & ASTHMA CARE, INC.

Account # _____
_____ Insurance Change
_____ Name/Add. Change

PATIENT INFORMATION

(Please Print)

PATIENT NAME (Last) _____ (First) _____ (M.I.) _____

STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____

Birth Date _____ Age _____ Sex _____ Home Ph. () _____ Cell Ph. () _____

Work Ph. () _____ Social Security # _____ Marital Status _____ E-Mail _____

Name/address of Referring M.D. _____

Patient's Employer: _____

Name/Address of Pharmacy _____

INSURANCE INFORMATION (All patient MUST provide policy holder information in this section)

PRIMARY INSURANCE: _____ Effective Date: _____

Address: _____

I.D.# _____ Group # _____

Policy Holder Date of Birth: _____ Sex _____

Patient Relation to Policy Holder: _____

Policy Holder's Name: _____ Policy Holder's Employer _____

SECONDARY INSURANCE: _____ Effective Date: _____

Address: _____

I.D.# _____ Group # _____

Policy Holder Date of Birth: _____ Sex _____

Patient Relation to Policy Holder: _____

Policy Holder's Name: _____ Policy Holder's Employer _____

ANY ADDITIONAL COVERAGE? () YES () NO

PATIENT INFORMATION *(continued)*

FINANCIAL RESPONSIBILITY (Person responsible if other than patient)

Must be filled out for ALL patients including minors

NAME (last) _____ (First) _____ (M.I.) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

Birth Date _____ Age _____ Sex _____ Home PH () _____ Cell PH () _____

Work Ph () _____ Social Security # _____ Marital Status _____

Name/Address of Primary Care and/or Referring Physician _____

EMPLOYER _____

IS THERE A THIRD PARTY INVOLVED? (i.e. Work Related, Auto Accident)? () Yes () NO

IF YES, Date of Accident _____ Employer at Time of Accident _____

Please present your insurance card(s) to the receptionist when you have completed this form and sign below.

I hereby authorize treatment. I authorize release of any medical information necessary to process this claim. I understand that my medical insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor, and that I am ultimately responsible for medical fees incurred during my care of care of my dependents.

I hereby authorize Allergy & Asthma Care, Inc. to apply for benefits on my behalf for covered services rendered by them. I also assign all insurance benefits directly to the doctor. I certify that the information I have reported above is correct and true. I permit a copy of this authorization to be used in place of the original.

DATE: _____ X _____

Signature (if minor, please have responsible party sign)

APPOINTMENT REMINDERS

- **Day of your Appointment:**
 - Set aside approximately **3 hours** for your appointment
 - Eat prior** to your appointment
 - Arrive 15 minutes prior** to your scheduled appointment time
 - Bring completed Patient Information Form and Patient History Questionnaire**
- **Prior to your Appointment:**
 - DO NOT STOP** taking your **ASTHMA MEDICATIONS**
 - Seven days prior** to your appointment, **discontinue** taking any medications containing **antihistamines**
 - Examples of antihistamines:**
 - Cold & Sinus Medicines
 - Benadryl
 - Claritin
 - Zyrtec
 - Allegra
- **Helpful information to bring to your appointment:**
 - List of Medications** you are taking
 - Records** pertaining to your visit concerning allergies or asthma
 - List of questions** you have for the doctor
 - Name/Address** of physicians you see
 - Insurance Card(s)**
- **Clothing:**
 - Skin testing** could be applied to your lower arms and it would be helpful if you could wear short sleeves.
- **Billing:**
 - Co-pay/co-insurance** will be **collected at time of service**
 - Deductible:** if deductible has **not been met**, be prepared to **pay a percentage**
 - Payment:** we accept **Cash, Check, MasterCard, Visa** and **Discover**
 - Questions:** Any questions or concerns you may have about your insurance, please call our **Insurance Department (1.513.671.0799)** during regular business hours.

We look forward to providing you with quality healthcare.

John Seyerle, M.D.

Ashish Mathur, M.D.

Allergy & Asthma Care, Inc. Staff