Allergy & Asthma Specialty Clinic

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Welcome to the Allergy & Asthma Specialty Clinic. We specialize in the care of adults and children with allergies, asthma, eczema, hives, anaphylaxis and immunodeficiency.

During your initial visit, a detailed history and physical examination, pulmonary function test (if you have asthma) and allergy skin tests will be performed. For most allergy-related illnesses, every effort will be made to accomplish these tests in one visit.
Please review the following information carefully.

Appointment Scheduled For: _____

Appointment Date/Time: _____

Clinic Site: Willmar Office (1037 19th Ave SW)
Hutchinson Health Clinic (3 Century Ave SE)
Marshall Avera Hospital Outreach Area (300 S. Bruce St.)

IMPORTANT: YOU MUST STOP TAKING ALL ANTIHISTAMINE (anti-allergy) MEDICATIONS FOR 7 DAYS PRIOR TO YOUR APPOINTMENT. ***Taking an antihistamine would interfere with allergy skin testing.*** If you have any questions about your medication, please call our office and we will be happy to assist you. Some examples of common antihistamines are listed on page 2.

CHECKLIST - BRING THE FOLLOWING TO YOUR APPOINTMENT:

- ☐ **Patient History Questionnaire** (enclosed). Complete the LEFT SIDE of the form only.
- ☐ **Patient Registration Form** (enclosed). Complete - do not leave any questions blank.
- ☐ **Patient Insurance Card(s)** including prescription plan card. Please verify coverage if you are in a special network or need pre-authorization prior to your appointment. It is your responsibility to obtain referrals, if needed.
- ☐ **Patient Medical Records**. A copy of your previous allergy/asthma related medical records, especially any allergy testing or lung function testing performed, is needed for review. Contact your previous clinic to obtain these or you can find a records release form on our website www.willmarallergy.com to submit by mail or fax.
- ☐ **Medications**. All prescription and over-the-counter medications you are currently taking must be listed in the Patient History Questionnaire. Please bring them with to your appointment.
- ☐ **Method of Payment**. Copays are due at time of services. A payment of $200 may be requested if you have an unmet deductible.

IMPORTANT: YOU MUST STOP TAKING ALL ANTIHISTAMINE (anti-allergy) MEDICATIONS FOR 7 DAYS PRIOR TO YOUR APPOINTMENT. This includes combination antihistamine/decongestants and over-the-counter allergy medications. Please be aware that antihistamines can usually be found in antidepressants, sleep aids and almost always in cough & cold medicines. Some common antihistamines include Allegra (fexofenadine), Atarax (hydroxyzine), Benadryl (diphenhydramine), Claritin (loratadine), Dimetapp, Tylenol PM, Xyzal (levocetirizine) and Zyrtec (cetirizine).

You may continue taking nasal sprays (except Astelin, Patanase, and Dymista).
If you are taking medications for anxiety, depression or trouble sleeping, please contact our office prior to stopping them.

If you are taking asthma medications such as Advair, Symbicort, Dulera, Pulmicort, Asmanex, QVAR, Flovent, Ventolin, Xopenex, Proventil, albuterol, Maxair, Azmacort, Vanceril, Aerobid, Serevent, Accolate, Singulair or theophylline; it is important you continue taking them.

Please bring all of your current medications with to your appointment. Call if you have questions.

YOUR APPOINTMENT: Patients under 18 years of age must be accompanied by a parent or guardian. Initial appointments may take 1-2 hours so schedule appropriately and arrive 15 minutes early. As a courtesy to other patients and our office staff, please notify us at least 24 hours in advance if you must cancel or reschedule your appointment. If you fail to appear at your scheduled appointment without notification, we will not be able to schedule a future appointment. If you have questions or concerns, feel free to contact us toll free at 1-877-866-4824 or visit our website at www.willmarallergy.com.

FINANCIAL POLICY: Please understand that payment of your bill is considered a part of your treatment. We **urge** you to call us **prior** to your appointment to discuss the approximate cost of treatment. Please be prepared to pay the cost of your visit at the time of service (we accept checks, cash, and Visa and MasterCard). If you have current insurance please bring all insurance cards with you. We will file claims electronically to your insurance carrier; if any claim is disputed by the insurance company, the payment for that claim immediately becomes due. See our complete financial policy at the clinic.

REFERRALS: If you are questioning whether your insurance requires a referral, please call the number on the back of your card. Most BlueCross BlueShield policies do not require a referral, except the policy with the state of Minnesota shown on the upper right corner (example shown below).

LOCATION: Our Willmar clinic is located on the south side of 19th Ave SW between Rice Home Medical and Evangelical Free Church. Turn south onto 11th Street and make a quick left into our parking lot. Please call if you need help with directions.

We thank you for allowing us to assist you. Please call us if you have any questions about your visit to our office. See you soon!

PATIENT REGISTRATION FORM

Please complete all the information below in print, please do not leave any questions blank. Thank You!

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Mobile Ph: _____ Age: _____ Sex: _____

Race: _____ Marital Status: _____ PIN: _____ Language: _____

Email Address: _____

PRIMARY INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____ Phone: _____

Copay: _____ Co Ins: _____ Address: _____

City: _____ State: _____ Zip: _____ Guarantor: _____

Relationship: _____ Employer: _____ ID: _____ DOB: _____

SECONDARY INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____ Phone: _____

Copay: _____ Co Ins: _____ Address: _____

City: _____ State: _____ Zip: _____ Guarantor: _____

Relationship: _____ Employer: _____ ID: _____ DOB: _____

EMPLOYER INFORMATION:

Name: _____ Phone: _____ Status: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____

REFERRING PHYSICIAN INFORMATION:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

PRIMARY PHYSICIAN INFORMATION:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

MOTHER INFORMATION:

Name: _____

Address: _____

City/ST/Zip: _____

Home Ph: _____ Work Ph: _____

FATHER INFORMATION:

Name: _____

Address: _____

City/ST/Zip: _____

Home Ph: _____ Work Ph: _____

PHARMACY:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

REASON FOR VISIT:

Injury: Yes _____ No _____ If Yes, Was It Work Related: _____ Auto Accident: _____

Was it reported to your employer or auto insurance? _____ Yes _____ No Date of Injury: _____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for surgical or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

Sign (Patient or Guardian) _____ **Date:** _____

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Amy R. Ellingson, M.D.

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date of Appt: _____

Referring Physician: _____ Patient accompanied by: _____

Please complete the LEFT SIDE of this form (3 pages)

Check box if you experience these symptoms:

- ☐ Sneezing, itchy/runny nose
- ☐ Nasal congestion, plugging, snoring, mouth breathing
- ☐ Postnasal drip, throat clearing
- ☐ Itchy, watery eyes
- ☐ Frequent yellow/green nasal drainage
- ☐ Loss of taste or smell
- ☐ Sore throat, voice changes, hoarseness
- ☐ Recurrent ear infections
- ☐ Recurrent sinus infections
- ☐ Frequent headaches
- ☐ Coughing, tickle coughs, spells of coughing
- ☐ Wheezing or shortness of breath
- ☐ Shortness of breath with exercise or coughing

- ☐ Diagnosis of asthma made ____ years ago
- ☐ Number of past hospitalizations for asthma: _____
- ☐ Number of emergency room visits for asthma: _____
- ☐ Symptoms occur: (circle one) Daily / More than 2 days per week / Less than 2 days per week
- ☐ Symptoms occur at night: (circle one) Every night / More than once a week / 3-4 nights per month
- ☐ Use of albuterol: _____
- ☐ Last time prednisone was used? _____
- ☐ Days missed from school/work in past year? _____
- ☐ Possible reaction to food or drug
- ☐ Possible reaction to bee sting
- ☐ Eczema, dry/itchy skin
- ☐ Hives, swelling
- ☐ Other rashes _____
- ☐ Transfer of allergy care from Dr. _____
- ☐ Continuation of allergy shots started ____ years ago

These symptoms occur: (circle all that apply)
Spring, summer, fall, winter
Days or weeks at a time or all of the time.
Other: _____

Triggered by exposure to: (circle all that apply)
Smoke, dust, animals, mold, odors, perfumes, aerosols, mowing lawn, barns, raking leaves, cold air, temperature changes, dampness, menstrual cycle, emotional upset, viral infections, colds, or exercise.
Other: _____

PHYSICIAN NOTES

HPI: _____

PRIOR ALLERGY WORK-UP:

Sinus x-ray/CT _____ CXR _____
Sinus surgery _____
Skin tests _____ Date _____
Prior allergy shots - dates _____
Helped / no help
Reactions _____

Previous therapy tried:

_____ helped / no help
_____ helped / no help
_____ helped / no help
_____ helped / no help
_____ helped / no help
_____ helped / no help

MEDICATIONS

Please list all current medications including over-the-counter meds.
List the drug name, dosage, how many times a day it is taken, and when it was started.

If more room is needed, please attach a list. Bring meds with to your appointment.

PHYSICIAN NOTES

PAST MEDICAL HISTORY

Birth complications? _____

Breastfed? _____ months. Bottle fed? _____ months.

Any history of RSV, infant eczema, or infant reflux/colic? _____

Tuberculosis: exposure/infection/treatment _____

Hospitalizations or surgeries:

Age	Reason

Chronic health conditions:

Drug allergies:

_____ Reaction _____
_____ Reaction _____
_____ Reaction _____
_____ Reaction _____

Immunizations: (circle all that apply) Flu, pneumovax, prevnar, chickenpox, tetanus, other: _____

FAMILY HISTORY

Father: ☐ alive ☐ deceased at age ____ ☐ allergies ☐ asthma ☐ sinus ☐ other diseases _____
Mother: ☐ alive ☐ deceased at age ____ ☐ allergies ☐ asthma ☐ sinus ☐ other diseases _____

Brother(s): How many? _____ Medical problems: _____
Sister(s): How many? _____ Medical problems: _____
Children: How many? _____ Medical problems: _____

Other familial diseases (circle all that apply): High blood pressure, diabetes, heart disease, reflux, cancer, arthritis, emphysema, high cholesterol, thyroid disease, cystic fibrosis, other immune deficiency, or skin problems
Other: _____

SOCIAL HISTORY

Primary residence: ☐ One home ☐ Split between homes: _____
Current occupation: _____
School/Daycare: _____
Tobacco use: ☐ smoke cigarettes ☐ chew Amount per day: _____ packs/tins
Date began: _____ Date quit: _____ Total years of tobacco use: _____
Secondhand smoke exposure from: ☐ Mom ☐ Dad ☐ Spouse ☐ Other: _____
Do you drink caffeine? ☐ No
☐ Yes, I drink _____ cups/day of coffee/tea/pop
Hobbies/sports include: _____

CURRENT ENVIRONMENT/EXPOSURES

☐ House ☐ Farm ☐ Apartment ☐ Dorm ☐ Town ☐ Country
Age of dwelling? _____ How long have you lived there? _____
Cigarette smoke exposure: ☐ None ☐ Indoors ☐ Outdoors ☐ Work ☐ Daycare
Do you have any pets/animals? _____ What type? _____
Are your pets/animals indoors or outdoors? _____
Air conditioning: ☐ Central ☐ Room ☐ None ☐ Open windows
Heating system: ☐ Forced air ☐ Radiated ☐ Geothermal ☐ Other _____
☐ Gas ☐ Electric ☐ Fuel Oil ☐ Wood burning stove/fireplace
Age of heating system: _____ How often are the filters changed? _____
Basement: ☐ Dry ☐ Musty/damp ☐ Visible mold growth ☐ No basement
Do you use a dehumidifier? _____
Bedroom location: ☐ Basement ☐ Main level ☐ Second floor
Does the bedroom have carpet? _____ If yes, how old is it? _____
Type of bed (mattress, air, crib, etc.) and how old is it? _____
Do you use dust mite zippered encasings: ☐ Pillows ☐ Mattress ☐ None
Type of bedding (i.e. down comforter, feather pillow) _____
Do you use any air cleaners? _____
Do you use a clothes line? _____
Any specific exposures at work or school? _____
_____
_____
Latex exposure? _____
Do your symptoms improve when away from home? _____
_____
_____

REVIEW OF SYSTEMS (check if present)

☐ Growth and development problems
☐ Hearing/speech problems
☐ Fever, chills, night sweats, or significant weight loss/gain
☐ Sleep problems (snoring, apnea)
☐ Skin problems (besides eczema or hives)
☐ Joint swelling or pain
☐ Blood count problems (anemia)
☐ Eye problems (explain)
☐ Throat infections, hoarse voice, or trouble swallowing
☐ Heart problems (pain, racing heart)
☐ High blood pressure
☐ Upset stomach, nausea, vomiting, diarrhea or constipation
☐ Acid reflux, indigestion or ulcer disease
☐ Urinary or bladder problems
☐ Nerve or psychiatric problems
☐ Hormonal problems (hot flashes)
☐ Possible pregnancy or planned pregnancy
☐ Other: _____

PHYSICIAN NOTES