Allergy & Asthma Specialty Clinic

1037 19th Ave SW · Willmar, MN 56201
Phone: 320-214-1100
Fax: 320-214-1155
www.willmarallergy.com

Amy R. Ellingson, MD
JoLene Schlegel, RN, NP-C
Daniele Welvaert, RN, NP-C

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/Check-in time: ____
Clinic Site: Willmar Office (1037 19th Ave SW)

We will call to confirm your appointment. If your phone number changes you MUST let us know the new number. We may cancel your appt if we cannot contact you.

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 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. To allow us to focus on the care of the patient, **please do not bring other children to the appointment**.

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 policies do not require referrals, but it is your responsibility to obtain one, if necessary.

LOCATION: Our Willmar clinic is located on the south side of 19th Ave SW between Casey's and the Living Hope 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

PATIENT INFORMATION
Last Name ____________________ First Name ____________________ Middle_________________ DOB ____________
Address ____ City _____________________ State _____ Zip ___________
Home Phone ________________ Work Phone ________________ Cell Phone________________ Age _____ Sex _____
Race __________________ Martial Status _________________ SSN __________________ Language _____________
Email address____

PRIMARY INSURANCE INFORMATION
Insurance Company ____ Phone ____________________
Policy Number_________________________________ Group Number__________________
Guarantor_______________________ Guarantor's DOB ___________ Guarantor's Employer ______________________
Patient's Relationship to Guarantor _________________

SECONDARY INSURANCE INFORMATION
Insurance Company ____ Phone ___________________
Policy Number_______________________________________ Group Number ________________________
Guarantor ______________________ Guarantor's DOB _____________ Guarantor's Employer _______________________
Patient's Relationship to Guarantor ________________________

EMPLOYER INFORMATION
Company ____ Phone ________________

PRIMARY PHYSICIAN/PROVIDER INFORMATION
Name ________________________________ Clinic Name ___________________________ Phone__________________
Address _______________________________________ City ___________________ State _______ Zip _________

REFERRING PHYSICIAN/PROVIDER INFORMATION (if different than primary physician)
Name ________________________________ Clinic Name ___________________________ Phone__________________
Address _______________________________________ City ___________________ State _______ Zip _________

EMERGENCY CONTACT INFORMATION
Name ____________________________________ Home Phone ________________ Cell Phone __________________
Address ______________________________________ City ______________________ State ______ Zip ___________

If the patient is a minor, please complete the following.

MOTHER'S INFORMATION
Name ______________________________________
Address ____________________________________
City/State/Zip________________________________
Home Phone _________________________________
Cell Phone __________________________________

FATHER'S INFORMATION
Name ______________________________________
Address ____________________________________
City/State/Zip _______________________________
Home Phone _________________________________
Cell Phone __________________________________

PHARMACY
Name ____ Phone______________________ Fax_________________
Address ____ City _______________ State _____ Zip _______

AUTHORIZATION TO PAY:I authorize payment directly to the business office of this clinic for medical benefits. I understand that I am financially responsible for the charges not covered by my insurance.
Signature (Patient or Guardian) ____________________________________ Date______________________

Allergy & Asthma Specialty Clinic

Amy R. Ellingson, MD
JoLene Schlegel, RN, NP-C
Daniele Welvaert, RN, NP-C

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.

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, COVID-19, pneumovax, prevnar, chickenpox, tetanus, other: ______________________________

FAMILY HISTORY

Father: ☐ alive ☐ deceased at age ____ ☐ allergies ☐ asthma ☐ sinus ☐ othe __________

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: ____
____
____

PHYSICIAN NOTES

____
____
____
____
____

SOCIAL HISTORY

Primary residence: ☐ One home ☐ Split between homes: ____________________
Current occupation: ____________________
School/Daycare: ____________________
Tobacco use: ☐ smoke cigarettes ☐ chew ☐ vaping 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