Date_____

9601 Blackwell Road ● Suite 350 ● Rockville, MD 20850 ● 301-545-5512 ● 301-979-9090
Fax www.schreiberallergy.com

ALLERGY QUESTIONNAIRE

Please complete as carefully as possible. All information is confidential and will help us determine what is causing your symptoms.

Patient Name_____
Street Address_____
City_____State _____Zip Code_____
Cell Phone_____
Home Phone _____
Work Phone_____
Occupation _____
Place of Employment _____

Email_____
Patient Birthdate_____ Age_____
Gender Male ○ Female ○ _____ ○
Married ○ Single ○ Other ○
Referred By_____
Pediatrician/Family Practitioner_____
Do we see your family member(s)? Yes ○ No ○
Name(s)_____

For PEDIATRIC Patients:
Parent's Name _____Occupation_____
Parent's Name _____Occupation_____

For ADULT Patients:
Spouse's Name _____Occupation_____
Employer_____ Work Phone_____

The reason for your visit today: _____
_____

MEDICAL HISTORY:

Please list any **chronic medical conditions/past illnesses**: _____
_____

Please list any known **food allergies** and associated **reactions**:_____

For PEDIATRIC Patients:

Full Term Pregnancy: Yes ○ No ○_____
Complicated Pregnancy: Yes ○ No ○_____
C-section Delivery: Yes ○ No ○
Birth Weight:_____lbs_____oz
Breast Feeding: Yes ○ No ○ ..... to age_____
Bottle Feeding: Yes ○ No ○ ..... to age_____

Feedings Tolerated Well: Yes ○ No ○
Whole Milk: Yes ○ No ○ began at age_____
Immunizations up to date: Yes ○ No ○
Parents of patient are: Married ○ Separated ○ Divorced ○
Primary residence is: One home ○ Split between homes ○

SURGICAL HISTORY:

Please list any **surgeries**:_____
_____

BIRTH FAMILY HISTORY:

	Alive & Well	Seasonal Allergies	Asthma	Eczema	Hives	Drug Allergy	Food Allergy	
Father	☐	☐	☐	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	☐	☐	☐	_____
Brother	☐	☐	☐	☐	☐	☐	☐	_____
Sister	☐	☐	☐	☐	☐	☐	☐	_____
Daughter	☐	☐	☐	☐	☐	☐	☐	_____
Son	☐	☐	☐	☐	☐	☐	☐	_____
M. Grandfather	☐	☐	☐	☐	☐	☐	☐	_____
M. Grandmother	☐	☐	☐	☐	☐	☐	☐	_____
P. Grandfather	☐	☐	☐	☐	☐	☐	☐	_____
P. Grandmother	☐	☐	☐	☐	☐	☐	☐	_____
Other _____	☐	☐	☐	☐	☐	☐	☐	_____

Please list any other chronic condition (e.g. cystic fibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc) along with the corresponding family member:_____

CURRENT ENVIRONMENT:

	Yes	No	
Personal History of Smoking	○	○	_____
Tobacco Exposure	○	○	_____
Pets (how many? type?)	○	○	_____
Carpeting	○	○	_____
Damp Basement	○	○	_____
Houseplants	○	○	_____
Air Cleaner	○	○	_____
Central A/C	○	○	_____
Forced Air Heat	○	○	_____
Down Comforter	○	○	_____
Feather Pillow	○	○	_____
Stuffed Animals	○	○	_____

Last **Flu Shot** (approx. date):_____

SYMPTOMS ARE MADE WORSE BY:

☐ Colds ☐ Foods
☐ Cigarette Smoke ☐ Cats
☐ Mowing Grass ☐ Dogs
☐ Raking Leaves ☐ Heat
☐ Perfumes or Scents ☐ Cold
☐ Dusting/Cleaning ☐ Other _____

THESE SYMPTOMS OCCUR:

☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Days or weeks at a time ☐ All the time
☐ At home Room _____
☐ Worse outside ☐ At work ☐ At school
☐ All day ☐ Worse at night or morning

Transfer of allergy care from Dr. _____
Continuation of allergy shots started _____years ago
Diagnosis of asthma was made _____years ago
Number of past hospitalizations for asthma_____

Days of school/work missed in past year_____
Number of ear infections in the past year_____
Number of sinus infections in the past year_____
Number of pneumonias during lifetime_____

LABORATORY TESTS:

	Where Done	Date	Normal	Abnormal
Chest / Sinus X-ray			○	○
Sweat Test			○	○
TB Skin Test			○	○
Allergy Skin Test			○	○

MEDICATION INFORMATION:

Please list any known **drug allergies** and associated **reactions**:_____

Pharmacy name and address:_____

Please list your current medications below:

Medication Name	Dosage	Frequency Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS:

	Yes	No	
Fever	○	○	_____
Recent weight loss	○	○	_____
Itchy eyes	○	○	_____
Excessive tearing	○	○	_____
Nasal Congestion	○	○	_____
Runny Nose (rhinorrhea)	○	○	_____
Sneezing	○	○	_____
Snoring	○	○	_____
Post-nasal Drip	○	○	_____
Heart problems	○	○	_____
Cough, productive (wet)	○	○	_____
Cough, non-productive (dry)	○	○	_____
Wheezing	○	○	_____
Heartburn/indigestion	○	○	_____
Other abdominal pain	○	○	_____
Nausea/vomiting	○	○	_____
Diarrhea	○	○	_____
Urinary or bladder problems	○	○	_____
Joint swelling or pain	○	○	_____
Skin rash	○	○	_____
Eczema	○	○	_____
Hives (urticaria)	○	○	_____
Nerve problems	○	○	_____
Psychiatric problems	○	○	_____
Hormone problems/hot flashes	○	○	_____
Easy bruising/bleeding	○	○	_____
Blood count problems (anemia, etc)	○	○	_____
Severe/recurrent infections	○	○	_____

Schreiber Allergy

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Kristin Sokol, M.D., FAAAAI
Jennifer L. Schaeffer, PA-C
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Emergency Contact and Insurance Information

Patient Name_____DOB _____
Patient Home _____ Cell _____ Work _____
Email_____
Emergency Contact Name_____
Emergency Contact Number_____
Please check your preference:
May we leave a message (may include test results) on your:
___☐__Home Phone ___☐__Cell Phone ___☐__Office Phone
___☐__Never leave a message, only speak with me
May we leave a message (may include test results) with your:
___☐__Spouse ___☐__Parent ___☐__Significant Other
___☐__Other, please specify_____

Insurance Company_____
Insurance ID Number_____
Insurance Group Number_____
Name of Policy Holder _____
Policy Holder's Sex _____Male _____Female
Policy Holder's Date of Birth_____
Policy Holder's Social Security Number_____
Policy Holder's Street Address _____

This policy is through the patient's employer ___◯__Yes ___◯__No
Policy Holder's Employer_____

Patient's Relationship to Policy Holder ___◯__Wife ___◯__Husband ___◯__Child

Do you have another health insurance company? ___◯__Yes ___◯__No
If yes, Name of Insurance company _____
Insurance ID Number_____
Insurance Group Number_____
Name of Policy Holder_____

Schreiber Allergy has my permission to bill the insurance companies listed above for services rendered to me or my dependent. I certify that the insurance information is accurate.

_____ _____
Date Signature of Patient or Parent/Guardian

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PAYMENT POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are also eager to help you receive your maximum allowable benefit. We do need your assistance and your understanding of our payment policy.

Co-payments are required at the time of service. We accept cash, checks, Discover, Mastercard, and Visa.

Due to the changing health insurance laws and regulations, we cannot guarantee that all services will be covered by your insurance policy. **In the event that your insurance does not cover your services and/or supplies (including allergy serum), you will be held responsible for payment.**

CANCELLATION POLICY

We require 24 hours notice for any cancellations. Failure to do so may result in a $50.00 fee.

We strive to provide medical services on a cost-efficient basis. If you have any questions concerning these policies or any uncertainty regarding insurance coverage, please do not hesitate to ask us. Please sign below indicating that you understand the billing practice of

Schreiber Allergy.

_____ _____

Responsible party's printed name and date Signature of responsible party

_____

Printed patient's name (if applicable)

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Notice of Privacy Practices

Dear Patient,

At your visit, you will be given information that describes how medical information about you may be used and disclosed. Please review it carefully.

Your information is important and confidential. Our ethics and policies require that your information is held in strict confidence.

Please sign below once you have received the privacy notice.

Signature_____

Date_____

Patient Credit Card on File Agreement

We have implemented a policy that enables you to maintain your credit card information securely on file with **Schreiber Allergy, LLC**. In providing us with your credit card information, you are giving **Schreiber Allergy, LLC** permission to automatically charge your credit card on file [or for any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Outstanding Balance: If you have a balance after claims have been made to insurance, you will receive a statement in the mail. If after 90 days we do not receive a response from you or your payment in full, any balance owed will be charged to your credit card. A copy of the charge will be sent by email to you.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person (s) listed below.

I authorize Schreiber Allergy, LLC to charge co-pays and any outstanding balance on my account to my credit card:

VISA _____ Mastercard _____ Discover _____

Credit Card Holder's Name: _____

Credit Card Number: _____

Expiration Date: _____ CVC: _____

Patient Name : _____
(Please Print)

Patient Name : _____

Patient Name : _____

Signature: _____ Date: _____

Office Use: Entered date _____