



Dear New Patient,

Thank you for making an appointment with Alabama Allergy & Asthma Center. Please complete the new patient packet following this letter, and bring it along with your insurance and driver's license to your first appointment. Please keep in mind that your first appointment can be lengthy due to the extensive information you will be provided to assist you in managing your continued good health.

Here are a few things to know for your first appointment:

- **Discontinue all Antihistamines FIVE days prior to your appointment.** Common medications containing Antihistamines are Benadryl, Triaminic, cough and cold medicines. Do not stop taking Singulair or asthma inhalers. For a complete list log-on to www.alabamaallergy.com and click on For Patients > Patient Forms.
- Please wear clothing that will allow for allergy testing with ease. A two piece outfit, ex., shirt and pants work best.
- We love children! However, if you are being allergy tested you will need to remain stationary and it will be difficult to keep an eye on small children.
- For Children we offer DVD players with children's programming and toys to keep them occupied during their appointment.
- Your visit as a new patient can last up to a few hours depending on testing needs. Please be prepared to stay at our office for the duration of your visit.

Remember that in order to be tested on the day of your initial visit you will need to discontinue certain medications five days prior to your appointment.

If you are concerned or have questions about which medications to discontinue, please do not hesitate to call our office.

We have five office locations. Please refer to the driving directions for your appointment location.

Should you wish to fill out the following new patient packet online, you can request a log-in for our Patient Portal from our staff by calling us at (205)871-9661.

You will receive an automated confirmation for your appointment, please confirm your appointment by email or text at least 24 hours before your appointment.

Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees.

Should you have any additional questions, please call us at (205) 871-9661.

We look forward to meeting you.

Sincerely,
The Staff of Alabama Allergy and Asthma Center

DRIVING DIRECTIONS TO ALABAMA ALLERGY & ASTHMA CENTER

HOMEWOOD OFFICE
504 Brookwood Boulevard
Homewood, AL 35209

From the South I-65 (Northbound): Take the Lakeshore Exit and turn Right at the light onto Lakeshore Drive.

From the North I-65 (Southbound): Take the Lakeshore Exit. Turn Left onto Lakeshore Drive.

- You will travel past Samford University and then pass under Highway 31
- Turn Right just after the Shell Gas Station onto Brookwood Boulevard
- Alabama Allergy will be on your LEFT just past BBVA Bank

From 280 West or East:

- Take the AL-149 ramp toward Homewood, and turn left onto Lakeshore Dr. .
- Pass Brookwood Mall and take a Left onto Brookwood Boulevard at the BBVA Compass Bank (just BEFORE Shell Gas Station)
- Alabama Allergy will be on your LEFT just past BBVA Compass Bank

From Highway 31

- Take the Lakeshore Dr. /Shades Creek Parkway/ AL-149 S exit
- Take your FIRST Right onto Brookwood Boulevard - at the Shell Gas Station
- Alabama Allergy will be on your LEFT
-

Our Homewood building is a gray building. Patient Parking is FREE and underneath our building.

CHELSEA
Chelsea Corners Shopping Center
16691 Highway 280
Chelsea, AL 35043

From Birmingham

- Hwy 280 East
- Follow 280 East 12 miles once you pass the Summit Shopping Center (or Hwy 459)
- Turn into the Chelsea Corners Shopping Center our building is a freestanding building in front of Winn Dixie Grocery Store

From Sylacauga

- Follow 280 West approximately 22 miles - make a U-Turn at County Road 440 at the traffic light
- After U Turn - make a Right into Chelsea Corners Shopping Center our office is a free standing building in front of Winn Dixie Grocery Store

HOOVER OFFICE
2100 Data Park Suite 200
Hoover, AL 35244

From I65

- Take Highway 31 South, cross under I 459, Pass the Galleria Mall on your right and take the next left onto LORNA Road.
- Follow Lorna Road approximately .3 miles and take a right onto Data Drive between Moe's and Arby's restaurants.
- We are the first building on the LEFT - main entrance is in the upper parking area.



HOOVER CONTINUED

From 459

- Exit at Montgomery Highway (Highway 31) South
- Pass the Galleria Mall on your right and take the first left after the mall at LORNA Road
- Follow Lorna Road approximately .3 miles and take a right onto Data Drive between Moe's and Arby's restaurants.
- We are the first building on the LEFT - main entrance is in the upper parking area.

From Highway 31

- From North or South - Turn onto Lorna Road (in-between Walgreens and Compass Bank)
- Follow Lorna Road .3 miles and take a right onto Data Drive between Moe's and Arby's restaurants
- We are the first building on the LEFT - main entrance is in the upper parking area.

CULLMAN OFFICE

1800 AL Hwy 157
POB 3 - Suite 100
Cullman, AL 35058

From Interstate 65:

- Take Exit 310 toward Cullman
- Travel 3.8 miles and take a LEFT into the main entrance of Cullman Regional Medical Center
- Take the first Right and Professional Office Building 3 will be immediately on your Left (we are on the 1st Floor of Cullman Primary Care)

ALABASTER OFFICE

1022 1st Street N
Suite 201
Alabaster, AL 35007

From Interstate 65:

- Take Exit 242 on to County Hwy 52 toward Pelham, Helena
- Turn left onto Pelham Parkway (also known as Highway 31) and travel 2 miles
- 1022 Building is located on the left
- Our office is Suite 201 (inside Shelby Dermatology)

TRUSSVILLE OFFICE

Shoppes at Deerfoot (Next to Publix)
7274 Gadsden Highway
Suite 100
Trussville, AL 35173

From Interstate 59 North or South

- Take Deerfoot Parkway Exit 143
- Turn left onto Deerfoot Pkwy and travel 1.5 miles
- Turn left on Gadsden Highway, andan immediate left into the Shoppes at Deerfoot
- Our office is next to Publix in Suite 100
- Free parking on site



MEDICATIONS TO HOLD FOR TESTING

Prescription Antihistamines

Atarax, Vistaril (Hydroxyzine)

Allegra (fexofenadine)

Clarinet

Periactin (Cyproheptadine)

Rondec

Pediatex

Pedi-Ox

Rynnatan

Q-DAL

Tussionate

Tussi-12

Tannihist

Xyzal

*Doxepin/Adapin/Sinequan will need to be held longer than 5 days, but DO NOT STOP it until you have seen the allergist

Over-the-Counter Antihistamines

Claritin, Alavert, Triaminic, Allerchews, Store Brand Non-Sedating Antihistamine (Loratidine)

Zyrtec (ceterizine)

Benadryl (Diphenhydramine)

Tavist (Clemastine)

Chlorpheniramine (Like Chlor-Trimeton, Actifed, Allerest)

NyQuil, Robitussin Night Cold, Tylenol Flu Night Time (Doxylamine)

Tylenol or Advil PM (contain diphenhydramine)

Dramamine (Dimenhydrinate)

Anything that contains Loratadine

Anything that contains Diphenhydramine

Anything that contains Brompheniramine

Anything that contains Chlorpheniramine

Anything that contains Carbinoxamine

Anything that contains Doxylamine

Anything that contains Clemastine

Anything that contains Tripolidine

Anything that contains Tripeleminamine

Any "Allergy" or "Cold" Preparation (like Tylenol Cold & Sinus or Advil Cold & Sinus)



Other Types of Medications to Hold 5 Days Before Allergy Testing

Anti-Nausea Medications

Dramamine (Dimhydrinate)
Doxylamine
Antivert, Bonine (Meclizine)
Phenergan (Promethazine)

Over-the-Counter Sleep Aids

Any "PM" Product (Like Tylenol PM or Excedrin PM or Alka Seltzer PM or Doan's PM)
Simply Sleep Nighttime Sleep Aid
Sominex
Anything that contains Diphenhydramine

Nasal and Eye Drops to Hold 48 Hours Before Allergy Testing

Prescription Nasal Sprays

Astelin Nasal Spray

Prescription Eye Drops

Patanol Eye Drops
Zaditor Eye Drops
Optivar Eye Drops
Elestat Eye Drops

All Over-the-Counter Eye Drops

Visine A Eye Drops
Op-Con A
Naph-Con A
Alomide Eye Drops

Medicines That You MAY CONTINUE & Should Not Interfere With Testing

Saline Nose Spray
Steroid Nose Sprays
Afrin Nose Spray
Singulair
Asthma Inhalers
Asthma Nebulizer Treatments
Nasalcrom
Crolom
Zycam
Mucinex (Guaifenesin)
Cough or Sinus Preparations that only contain Dextromethorphan and/or Guaifenesin and/or Pseudoephedrine
Plain Sudafed (Pseudoephedrine)
"Non-Drowsy" Cold Preparations EXCEPT NO LORATIDINE



ALLERGY HISTORY:

1. Have you ever had: Hay Fever/Seasonal Allergies Childhood Asthma Adult Onset Asthma
 Eczema Hives Allergic Eyes Insect Sting Reaction
 Food Allergies Swelling Latex Allergy Chemical Allergy

2. List all food allergies and describe the reaction and dates(s):

3. Have you ever been tested for allergies? Yes No When? _____
If yes, what type of testing did you have? Skin tests RAST (blood) tests
What were the test results? _____

4. Have you ever had allergy immunotherapy? Yes No
If yes, did they help? Yes No
If yes, please give provider name and year: _____

5. Have you ever had a severe reaction to an insect? Yes No
What insect? Honey Bee Yellow Jacket Wasp Hornet Fire Ant Other _____
Describe the reaction: _____

6. How many sinus infections per year do you get? 1 2-3 3-4 5 or greater None
7. How many lung infections per year do you get? 1 2-3 3-4 5 or greater None
8. How many courses of antibiotics per year do you get? 1 2-3 3-4 5 or greater None
9. How many steroid courses per year do you get? 1 2-3 3-4 5 or greater None

MEDICAL AND SURGICAL HISTORY:

LIST ALL SIGNIFICANT ILLNESSES OR MEDICAL PROBLEMS:

LIST ALL HOSPITALIZATIONS AND OTHER SURGERIES (INCLUDING YEAR AND REASON):

HAVE YOU EVER HAD:

- | | | | |
|----------------------------|--|------------------|---------------|
| a) Nasal or Sinus Surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What type? _____ | |
| | | When? _____ | Surgeon _____ |
| b) Tonsillectomy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | When? _____ | Surgeon _____ |
| c) Adenoidectomy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | When? _____ | Surgeon _____ |
| d) Ear Tubes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | When? _____ | Surgeon _____ |

FOR CHILDREN UNDER 15, COMPLETE THE FOLLOWING:

1. Birth Weight: _____
 2. Were there any complications following delivery?
 Yes No If yes, was there an intensive care unit stay? Yes No
 3. Were there any severe respiratory infections under age 8? Yes No
Please specify: RSV Pneumonia Severe bronchitis Croup Other _____
 4. Has growth and development been normal? Yes No If no, explain _____
 5. Are immunizations up to date? Yes No
-

SOCIAL HISTORY:

1. Current Occupation: _____
If a child, please indicate: Student-What Grade? _____ Daycare/Preschool Not Applicable
2. Marital Status: Single Married Divorced Widow Number of Children: _____
3. Do symptoms tend to improve: At home At work On vacation Not Applicable
4. Hobbies: _____
Do your hobbies involve any of the following? Chemicals Particulates Animals Outdoor sports

ENVIRONMENTAL HISTORY:

1. Do you reside in a single home an apartment/condo a mobile home
 2. When was your residence built? Prior to 1940 1940-1959 1960-1979 1980-1999 After 2000
 3. Is your home air-conditioned by Central air Window units None
 4. Does your home contain any of the following? Gas stove Wood burning stove Gas fireplace
 Gas furnace Wood burning fireplace
 5. Do any rooms in your home have moisture problems? Basement Crawlspace Living area
 Bedroom None
 6. Which rooms have carpet in your home? Living area/Den Master bedroom Other bedrooms
 7. Do you use allergy protective bedding? Mattress covers Pillow covers None
 8. Do you have pets? None Dogs: Cats: Other _____
 Inside Inside Inside
 Outside Outside Outside
 Both Both Both
 9. Do you utilize any of the following in your home? (please specify location)
 HEPA filter - Living area Bedroom Basement
 Electrostatic filter - Living area Bedroom Basement
 Whole house filter- Living area Bedroom Basement
 Humidifier- Living area Bedroom Basement
 None
- Do you have anyone that smokes living in your household? None Yes

ASTHMA CONTROL TEST:

If you are being seen for asthma or asthma symptoms, please circle the best answer to the following questions below:

(For Age 12 years or older)

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?
(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time
2. In the past 4 weeks how often have you had shortness of breath?
(1) More than once a day (2) Once a day (3) Three to six times a week (4) Once or twice a week (5) Not at all
3. In the past 4 weeks how often did your asthma symptoms wake you up at night or earlier than usual in the morning?
(1) 4 or more nights a week (2) 2 or 3 nights a week (3) Once a week (4) Once or twice (5) Not at all
4. In the past 4 weeks how often have you used your rescue inhaler or nebulizer medication?
(1) 3 or more times per day (2) 1 or 2 times a day (3) 2 or 3 times a week (4) Once a week or less (5) Not at all
5. How would you rate your asthma control in the past 4 weeks?
(1) Not controlled at all (2) Poorly controlled (3) Somewhat controlled (4) Well controlled (5) Completely controlled

Nurse Score _____

(For Ages 4 to 11 years)

1. (To the child) How is your asthma today?
(0) Very Bad (1) Bad (2) Good (3) Very Good
2. (To the child) How much of a problem is your asthma when you run, exercise, or play sports?
(0) It's a big problem, can't do what I want (1) It's a problem (2) It's a little problem, but okay (3) It is not a problem
3. (To the child) Do you cough because of your asthma?
(0) Yes, all of the time (1) Yes, most of the time (2) Yes, sometimes (3) No, none of the time
4. (To the child) Do you wake up at night because of your asthma?
(0) Yes, all of the time (1) Yes, most of the time (2) Yes, sometimes (3) No, none of the time
5. (To the parent) During the past 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?
(0) Everyday (1) 19-24 days/month (2) 11-18 days/month (3) 4-10 days/month (4) 1-3 days/month (5) Not at all
6. (To the parent) During the past 4 weeks how many days per month did your child wheeze during the day due to asthma?
(0) Everyday (1) 19-24 days/month (2) 11-18 days/month (3) 4-10 days/month (4) 1-3 days/month (5) Not at all
7. (To the parent) During the last 4 weeks how many days per month did you child wake up during the night due to asthma?
(0) Everyday (1) 19-24 days/month (2) 11-18 days/month (3) 4-10 days/month (4) 1-3 days/month (5) Not at all

Nurse Score _____

REVIEW OF SYSTEMS:

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
<u>General</u>			<u>Heart/Blood Vessels</u>			<u>Neurological</u>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chills or night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Pain/tightness in chest at rest or exercise	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Poor balance	<input type="checkbox"/>	<input type="checkbox"/>
Tired/Weakness/Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
						Difficulty with speech	<input type="checkbox"/>	<input type="checkbox"/>
						Tremors	<input type="checkbox"/>	<input type="checkbox"/>
						Headaches	<input type="checkbox"/>	<input type="checkbox"/>
<u>Skin/Hair</u>			<u>Gastrointestinal</u>			<u>Psychiatric</u>		
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Itchiness	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
			Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Eyes</u>			Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<u>Hematology</u>		
Worsening eyesight	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or low blood	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Recent loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ears, Nose & Throat</u>			<u>Endocrine</u>			<u>Women Only</u>		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Goiter/Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Frequent thirst	<input type="checkbox"/>	<input type="checkbox"/>			
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<u>Men Only</u>		
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>				Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	<u>Musculoskeletal</u>			Pain or lump in testicles or scrotum (sac)	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in neck	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
			Muscle aches/weakness	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Lungs</u>			Ulcers on legs or feet	<input type="checkbox"/>	<input type="checkbox"/>			
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>						
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<u>Genitourinary</u>					
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Urine infections	<input type="checkbox"/>	<input type="checkbox"/>			
			Pain/burning on urination	<input type="checkbox"/>	<input type="checkbox"/>			
			Difficulty with urination	<input type="checkbox"/>	<input type="checkbox"/>			
			Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>			
			Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			

I acknowledge that all information regarding my medical history is correct and accurate to my knowledge. By signing this document I understand that I am held accountable for any false information which could impede proper treatment provided by the physicians and staff of the Alabama Allergy & Asthma Center. I am aware that I am responsible for providing updated information to the physicians and staff of the Alabama Allergy & Asthma Center as changes occur in my medical history.

Signature: X _____

Date: _____