ALABAMA ALLERGY & ASTHMA CENTER™

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 now 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 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 seven office locations. Please refer to the driving directions for your appointment location.

Should you wish to fill out the new patient packed 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 addition 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 t 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 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.

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.

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

BESSEMER OFFICE
975 9th Ave SW, Suite 210
Bessemer, AL, 35022

From Interstate 20 W/59 S

- Take Exit 110 from 1-20 W/1-59 S
- Use left 2 lanes to turn left onto Splash Adventure Parkway
- Turn right onto 9th Ave SW (signs for Lawson State Community College/Bessemer Campus)
- Continue on Medical Center Drive to your destination.
- Office is located within UAB Medical West, Suite 210

From Interstate 20 E/59 N

- Take Exit 108 from 1-20 E/1-59 N
- Turn right onto Academy Drive
- Take immediate left turn onto 9th Ave SW
- Turn right at Medical Center Drive
- Office is located within UAB Medical West, Suite 210

Cullman Office
2108 Hwy 157
Cullman, AL, 35058

From East (1-65 N/1-65 S)

- Get off I-65 at Exit 310 (Cullman/Moulton)
- Turn right onto Hwy 157 if coming from I-65 North, Turn left onto Hwy 157 if coming from I-65. Continue for 4.1 miles.
- Turn left onto Dahlke Drive
- The location is on your immediate left.

From West (AL 69-S)

- Head west on AL 69-S
- Turn right onto AL-157 North
- Turn right onto Dahlke Drive
- The location is on your immediate left

From West (US-278 W)

- Head west on US-278 W
- Turn right onto AL-157 N
- Turn right onto Dahlke Drive
- The location is on your immediate left

MEDICATIONS TO HOLD FOR TESTING

Prescription Antihistamines

Atarax, Vistaril (Hydroxyzine)
Allegra (fexofenadine)
Clarinex
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 Diphenydramine
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 Tripelennamine
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 (Dimehydrinate)
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 Psudoephedrine
Plain Sudafed (Pseudoephedrine)
"Non-Drowsy" Cold Preparations EXCEPT NO LORATIDINE

ALABAMA ALLERGY & ASTHMA CENTER

Thank you for choosing our office. In order to serve you properly, please complete the following information (7 pages) and bring it along with your insurance card and state issued identification card to your first appointment.

Date__/__/__ Patient name _____
FIRST MI LAST

SSN ___-___-_____ ☐ Male ☐ Female Birthdate __/__/___ Home # _____

Address _____ City _____ State____ Zip_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Email address _____ CELL Phone # _____

Patient or parent employer _____ Best # _____

Spouse or parent's name _____ Best # _____

Person to contact in case of emergency _____ Best # _____

Primary Care Physician _____

Referring Physician (if applicable) _____

Responsible Party

Name of person responsible for this account _____ **Relationship to patient** _____

Address _____ Home #_____

SS #_____ Birthdate _____ Employer _____

Insurance Information

Name of insured _____ **Relationship to patient** _____

Birthdate _____ SSN _____ Employer's name _____

Insurance company _____ ID # _____

Group # _____ Insurance phone # _____

Does your insurance require referrals from your primary physician? ☐ Yes ☐ no

Do you have any additional insurance? ☐ Yes ☐ no If yes, complete the following:

Name of insured _____ **Relationship to patient** _____

Birthdate _____ SSN _____ Employer's name_____

Insurance company _____ ID # _____

Group # _____ Insurance phone # _____

Authorization & Release - The undersigned agrees, whether he signs as agent or as a patient, that in consideration of agreed upon services to be rendered, including allergy extracts and injections, by the Alabama Allergy & Asthma Center to the patient, he hereby obligates himself, assumes financial responsibility, and agrees to pay upon request to provider all charges for such services incurred by said patient. All deductibles, co-payments and co-insurance are due at the time of service. **Should the account be referred to an attorney/collection agency for collection, the undersigned shall pay all responsible attorney fees and collection expenses. The undersigned understands that all bills are payable upon presentation and that he, not the insurance company, is responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. All balances beyond the contracted insurance rates are payable by the patient due of receipt of a patient statements mail. I hereby authorize Alabama Allergy & Asthma Center to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered to patient.** I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify the Alabama Allergy & Asthma Center if any of my information should change or if my identity is compromised or stolen.

Signature of patient (or parent/guardian if a minor) **Date:**

X_____ _____

APPOINTMENT DATE: _____

NAME: _____ DATE OF BIRTH: _____

PHONE: Home: _____ Cell: _____

Referring Physician, if applicable: _____

Primary Care Physician: _____

DESCRIBE IN YOUR OWN WORDS THE REASON FOR THIS VISIT:

_____

_____

ALL CURRENT MEDICATIONS:

LIST CURRENT MEDICATIONS AND BRING THEM TO YOUR APPOINTMENT. (Include over-the-counter medications/supplements)

Medicine	Dosage	How Often?

Pharmacy Name_____ Location_____ Phone_____

DRUG ALLERGY HISTORY: LIST ALL DRUG ALLERGIES AND DESCRIBE THE REACTION AND DATE(S):

If you do NOT have drug allergies, please indicate by checking this box ☐ (No known drug allergies)

_____

_____

_____

----------NURSE ONLY-DO NOT WRITE BELOW----------

VITALS: Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ O2 Sat: _____ PFR_____

Problem list present: Yes / No

Permissible ERx given: Yes / No

Transition: In/New Pt-Yes- Med Rec done____

BMI noted and Information provided: Yes / No

Educational Resources provided and documented: Yes / No

Smoking Cessation provided: Yes / No

Copy of Plan/Summary Provided: Yes / No

Preventative Care Documented: Yes / No

Advance Directive noted: Yes/No/NA

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? ☐ Yes ☐ No What type? _____
   When?_____ Surgeon _____
b) Tonsillectomy? ☐ Yes ☐ No When?_____ Surgeon _____
c) Adenoidectomy? ☐ Yes ☐ No When?_____ Surgeon _____
d) Ear Tubes? ☐ Yes ☐ 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

FAMILY HISTORY:

Please indicate if you have a family history of any of the following.

	Mother	Father	Sibling	Child
Asthma	☐	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Recurrent infections	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐
Insect Reactions	☐	☐	☐	☐
Drug Reactions	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐
Swelling	☐	☐	☐	☐

Other _____

PREVENTATIVE MEASURES:

1. Smoking Status: (please check) ☐Never Smoked ☐Current smoker: How often? _____
   ☐Previous smoker: Year that you quit? _____
2. Have you received the Influenza vaccine within the past 12 months? ☐Yes ☐No
   If yes, when _____
3. If you are age 40 or above, have you ever received the pneumonia vaccine? ☐Yes ☐No
   If yes, _____
4. If you are age 40 or above, have you ever had a colonoscopy? ☐ Yes ☐ No
   If yes, when _____
5. If you are age 60 or above, do you currently have an advance directive or living will? ☐Yes ☐No

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?

General — YES NO

- Fever
- Chills or night sweats
- Weight loss
- Weight gain
- Tired/Weakness/Fatigue

Skin/Hair — YES NO

- Rash
- Hives
- Itchiness
- Eczema

Eyes — YES NO

- Worsening eyesight
- Cataracts
- Glaucoma
- Pain
- Infection

Ears, Nose & Throat — YES NO

- Dizziness
- Loss of hearing
- Earache
- Ringing in ears
- Nose bleeds
- Sore throat
- Hoarseness
- Mouth sores
- Thrush
- Pain in neck

Lungs — YES NO

- Cough up blood
- Pneumonia
- Shortness of breath
- Chronic bronchitis

Heart/Blood Vessels — YES NO

- High blood pressue
- Pain/tightness in chest at rest or exercise
- Heart murmur
- Heart Palpitations
- Pace maker

Gastrointestinal — YES NO

- Heartburn
- Nausea
- Vomiting
- Stomach pain
- Diarrhea
- Constipation
- Hemorrhoids
- Bloody stools
- Recent loss of appetite
- Jaundice
- Hepatitis
- Ulcer

Endocrine — YES NO

- Goiter/Thyroid problem
- Diabetes mellitus
- Frequent thirst
- Frequent urination
- Heat intolerance
- Cold intolerance

Musculoskeletal — YES NO

- Joint pain
- Arthritis
- Muscle aches/weakness
- Ulcers on legs or feet

Genitourinary — YES NO

- Frequent urination
- Urine infections
- Pain/burning on urination
- Difficulty with urination
- Blood in urine
- Kidney stones

Neurological — YES NO

- Seizures
- Tingling
- Numbness
- Poor balance
- Stroke/paralysis
- Difficulty with speech
- Tremors
- Headaches

Psychiatric — YES NO

- Anxiety
- Memory loss
- Panic disorder
- Bipolar
- Schizophrenia

Hematology — YES NO

- Anemia or low blood
- Bruise easily
- Swollen glands
- Blood clots
- Blood transfusions

Women Only — YES NO

- Menstrual problems
- STD

Men Only — YES NO

- Prostate trouble
- STD
- Discharge from penis
- Pain or lump in testicles or scrotum (sac)

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: _____