



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](http://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 multiple office locations. Please refer to the driving directions for your appointment location.

Should you wish to fill out the 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
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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 1<sup>st</sup> 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, and an 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



OXFORD OFFICE

641 Snow Street

Oxford, AL 36203

**From AL-49 North**

- Follow AL-49 North and I-20 W to South Quintard Ave in Oxford.
- Take exit 185 from I-20 West
- Follow South Quintard Ave and turn right onto Snow Street
- Follow Snow Street and turn right just past Dollar General into Snow Village
- We are located behind Honey Baked Ham

**From US-431 South**

- Follow US-431 South to Calhoun County
- Follow McCellan Blvd and AL-21 South
- From S Quintard Ave turn left onto Snow Street
- Follow Snow Street and turn right just past Dollar General into Snow Village
- We are located behind Honey Baked Ham

**From I-20 East**

- Follow I-20 East to AL-21 North in Oxford
- Take exit 185 from I-20 East
- Follow AL-21 North and Snow Street
- Turn left right past Dollar General into Snow Village
- We are located behind Honey Baked Ham

**From I-20 West**

- Follow I-20 West to S Quintard Ave in Oxford
- Take exit 185 from I-20 West
- Follow S Quintard Ave and Snow Street
- Turn right into Snow Village
- We are located behind Honey Baked Ham



## FORT PAYNE OFFICE

**1906 Glenn Blvd Suite 300  
Fort Payne, AL 35968**

### From East (I-65 N/I-65 S)

- Get off I-65 at Exit 250 to merge onto I-459 N (Atlanta/Gadsden)
- Use the right 2 lanes to take exit 250 to merge onto I-459 N toward Atlanta/Gadsden
- Use the right 2 lanes to take exit 33B to merge onto I-59 N toward Gadsden
- Take exit 218 for AL-35 toward Fort Payne/Rainsville
- Follow Glenn Blvd SW/Pine Ridge Rd SW to your destination
- The location in the strip mall next to Chick-Fil-A

### From West (AL 69-S)

- Take AL-69 N and AL-91 N to US-278 E in Holly Pond
- Follow US-278 E and I-59 N to AL-35 N/Glenn Blvd SW/Pine Ridge Rd SW in Fort Payne.
- Take exit 218 from I-59 N
- Follow Glenn Blvd SW/Pine Ridge Rd SW to your destination
- The location in the strip mall next to Chick-Fil-A

### From West (US-278 W)

- Head southeast on US-278 E toward Co Rd 469
- Turn right onto US-278 E/US-431 S
- Turn right onto 5th Ave NW
- Turn left to merge onto I-59 N toward Chattanooga
- Take exit 218 for AL-35 toward Fort Payne/Rainsville
- Follow Glenn Blvd SW/Pine Ridge Rd SW to your destination
- The location in the strip mall next to Chick-Fil-A

## 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):

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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:

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

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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
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**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insect Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____				

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## PREVENTATIVE MEASURES:

- Smoking Status: (please check)  Never Smoked  Current smoker: How often? \_\_\_\_\_  
 Previous smoker: Year that you quit? \_\_\_\_\_
  - Have you received the Influenza vaccine within the past 12 months?  Yes  No  
If yes, when \_\_\_\_\_
  - If you are age 40 or above, have you ever received the pneumonia vaccine?  Yes  No  
If yes, \_\_\_\_\_
  - If you are age 40 or above, have you ever had a colonoscopy?  Yes  No  
If yes, when \_\_\_\_\_
  - If you are age 60 or above, do you currently have an advance directive or living will?  Yes  No
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## 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
<b><u>General</u></b>			<b><u>Heart/Blood Vessels</u></b>			<b><u>Neurological</u></b>		
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"/>
<b><u>Skin/Hair</u></b>			<b><u>Gastrointestinal</u></b>			<b><u>Psychiatric</u></b>		
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"/>			
<b><u>Eyes</u></b>			Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Hematology</u></b>		
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"/>
<b><u>Ears, Nose &amp; Throat</u></b>			<b><u>Endocrine</u></b>			<b><u>Women Only</u></b>		
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"/>	<b><u>Men Only</u></b>		
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"/>	<b><u>Musculoskeletal</u></b>			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"/>			
<b><u>Lungs</u></b>			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"/>	<b><u>Genitourinary</u></b>					
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: \_\_\_\_\_