The Allergy and Asthma Center, P.C.

David Mangold, PA-C
95 Indian Trail Rd.
Kalispell, MT 59901
(406) 300-4882

WELCOME!
We look forward to providing your care. Before your first appointment, please read and familiarize yourself with AAC's office policies below.

PAPERWORK
Please complete the enclosed registration and questionnaire. Please take the time to fill out these forms completely and accurately. **All paperwork must be completed PRIOR to your scheduled appointment time. Please be aware that if your paperwork is not completed when you arrive for your appointment, you may be rescheduled.** Please also bring your completed paperwork, insurance card, and any required copayment to your appointment, if applicable.

ALLERGY TESTING
If you are scheduled to have allergy testing completed at your appointment, **please review the medications list on the reverse of this letter and STOP medications**, as appropriate. If you have any concerns about discontinuing any of your medications, please contact our office immediately.

APPOINTMENT
Your appointment is scheduled for _____ at _____

Please arrive 10 minutes prior to your scheduled appointment time to check in.
in Kalispell with David Mangold, PA-C.

CANCELLATION POLICY
Should you need to cancel your appointment, we require 24 hours notice. We understand that emergencies do occur, but habitual same day cancellations will have a $50.00 charge assessed to your account. Please honor your appointments as best you can to avoid being charged this fee.

NO ANIMALS ALLOWED IN CLINIC
We understand that there are patients who have service animals; however, because there are other patients who have appointments, and may be receiving immunotherapy due to allergies to certain animals, we do not allow animals in the clinic. Thank you for your cooperation.

We look forward to meeting with you soon!

Thank you,

The Allergy and Asthma Center Staff

Medications Patients Must Stop Using Before Initial Visit or Skin Testing

48 HOURS

- Tagamet (cimetidine)
- Zantac (ranitidine)
- Pepcid (famotidine)
- Axid (nizatidine)
- Benedryl (diphenhydramine)
- Tylenol PM
- Phenergan (promethazine)
- Motion sickness medications
- Topical steroid creams on testing sites (back and arms)

ONE WEEK

- Any over the counter antihistamine medications
- Allegra (fexofenadine)
- Zyrtec (cetirizine)
- Xyzal (levocetirizine)
- Claritin (loratadine)
- Clarinex (desloratadine)
- Alavert (loratadine)
- Atarax (hydroxyzine)
- Astelin / Astepro (azelastine) – nasal spray
- Patanase (olopatadine) – nasal spray
- Zatidor / Alaway (ketotifen) – eye drops
- Patanol / Pataday (olopatadine) – eye drops
- Optivar (azelastine) – eye drops
- Livostin (levocabastine) – eye drops
- Elestat (epinastine) – eye drops

TWO WEEKS

All of these are a specific class of antidepressant, any other antidepressants are okay
THESE MEDICATIONS SHOULD NOT BE STOPPED UNLESS YOU CONSULT WITH YOUR DOCTOR.

- Tofranil (imipramine)
- Anafranil (clomipramine)
- Aventyl, Pamelor (nortriptyline)
- Elavil, Endep (amitriptyline)
- Norpramin (desipramine)
- Sinequan (doxepin)
- Surmontil (trimipramine)
- Vivactil (protriptyline)
- Luvox (fluvoxamine)
- Remeron (mirtazapine)

If you are reluctant to stop your medication we can still see you, but it may require a second visit for testing.

Allergy and Asthma Center, PC
Patient Registration Form

Patient Name:_____ Date completed _____
First Middle Initial Last

Mailing Address _____City_____ State_____ Zip_____

Phone (_____)_____ May we leave messages with detailed health information and billing questions? _____

Please provide your email address for communication with providers about your healthcare:_____

Primary Physician _____Pharmacy_____

Social Security #_____ Birthday_____ Age _____ Sex_____
Month/Day/Year M/F

Place of Employment _____

Occupation _____ Status_____
Full-time/Part time

Work Phone # _____ May we contact you at work? _____Yes/No
Area Code/Work #/Extension

Marital Status_____ Spouse's Name and Birthdate_____
Single/Married

Please submit your insurance card or cards for copying.

Primary Insurance_____ Policy Holder _____
Name of Insurance Company

Secondary Insurance_____ Policy Holder _____
Name of Insurance Company

Is patient age 18+_____ Patient will receive statement unless AAC staff is notified of another person's responsibility
Y/N for payment on account if the answer is "Y".

If "N"
Mother/Guardian Name _____ Birthday_____ Age_____

Social Security # _____ Place of Employment _____

Occupation_____ Work # _____ Status _____
Full-time/Part-time

Address and Phone # if different than Patient _____

Father/Guardian Name _____ Birthday_____ Age_____

Social Security # _____ Place of Employment _____

Occupation_____ Work # _____ Status _____
Full-time/Part-time

Address and Phone # if different than Patient _____

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The Allergy and Asthma Center, PC
Patient Questionnaire

Patient Name _____ Birth Date _____

Referring Physician _____ Date Questionnaire Completed _____

CURRENT MEDICAL HISTORY

1. What are the primary medical complaints today:

_____

In the past year these problems are _____ worse _____ unchanged _____ better

2. List current medications (include dose and frequency):

_____

_____

_____

_____

3. Do you have any medication allergies? _____

If yes, list medication(s) and reaction: _____

_____

PAST MEDICAL HISTORY

1. Significant childhood illnesses: _____

2. Other Medical Problems: (Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Arthritis, Cancer, etc.)

_____

_____

3. Surgeries? _____ If yes, specify and give year: _____

_____

4. Hospitalizations? _____ If yes, specify and give year: _____

_____

5. *As an infant* did patient have: Colic _____ Eczema _____ Many formula changes _____

Constant runny nose _____ Breathing problems _____ Any adverse reactions to immunizations _____

6. Has patient ever had any of the following tests? Indicate year and place done:

Chest X-Ray? _____ Sweat Test? _____ Breathing Tests? _____

Sinus X-Rays or CT scan? _____ Cardiac tests (EKG, echo, stress test) _____

PERSONAL HISTORY

1. Is patient in school? _____ Grade? _____
2. Number of school or work days missed due to illness? _____
3. Has the patient ever smoked cigarettes? _____ Age patient began smoking cigarettes regularly? _____

   How many packs a day did the patient smoke? _____Does patient currently smoke? _____

   How old was patient when they quit? _____
4. Does patient drink alcohol regularly? _____
5. Does patient use any illegal drugs? _____
6. What has been the usual occupation or job for the patient? _____
7. Has the patient ever worked in any dusty or hazardous job? _____

   Specify which job, total years of work, and amount of exposure. _____

   _____
8. Has the patient ever been exposed to gas or chemical fumes at work?_____
9. Specify which job, total years of work, and amount of exposure. _____

   _____
10. List patient's hobbies? _____

    _____

FAMILY HISTORY

1. Mother: Age if living _____ Age at death _____ cause of death _____

   Father: Age if living _____ Age at death _____ cause of death _____
2. Does patient have any children? _____ If yes, list ages and any medical problems _____

   _____
3. Does patient have any siblings? _____ If yes, list ages and any medical problems _____

   _____

4. Please identify if parents (F/M), brother (B), sister (S), children (CH), grandparents (GF/GM) have any of the conditions listed below:

Asthma_____	Chronic Bronchitis _____	Hayfever_____
Sinus Trouble_____	Skin Allergy _____	COPD_____
Hives (welts) _____	Cystic Fibrosis _____	Emphysema _____
Autoimmune Disease_____	Repeated Infections _____	High Blood Pressure _____
Heart Disease _____	Arthritis _____	Other _____

ALLERGY HISTORY

1. Check any of the following symptoms that patient had or now has.

Nose and Throat

_____ Frequent Colds

_____ Chronic Congestion

_____ Chronic Nasal Discharge

_____ Chronic Sniffing

_____ Frequent Sneezing

_____ Frequent Rubbing/Itching

_____ Frequent Sore Throats

_____ Polyps

_____ Sinus Problems

_____ Headaches

_____ Post Nasal Drip

_____ Throat Clearing

_____ Snoring

Eyes

_____ Constant Circles

_____ Redness

_____ Itching/Rubbing

_____ Swelling

Chest

_____ Chronic Cough

_____ Shortness of Breath

_____ Wheezing

_____ Wheezing Attacks

_____ Tightness in Chest

_____ Exercise Intolerance

_____ Exercise Induced Wheezing

_____ Exercise Induced Cough

_____ Sputum or Phlegm

_____ Pneumonia

_____ Bronchitis

_____ Frequent Croup

Ears

_____ Congestion

_____ Frequent Infections

_____ Fluid

_____ Ear Tubes

_____ Hearing Loss

_____ Speech Problems

Skin

_____ Eczema

_____ Hives (welts)

_____ Dryness

_____ Frequent Rashes

Miscellaneous

_____ Reaction to Insect Bites

_____ Reaction to Insect Stings

2. Has patient ever had allergy tests? _____ When? _____ Findings? _____

3. Has patient ever had allergy shots? _____ If yes, did they help? _____

4. Does patient have any problems eating certain foods? _____

If yes, specify foods and describe symptoms: _____

_____

_____

5. Check any of the following medicines or types of medicines you have used to treat your problem (s):

_____ Antihistamines (Allegra, Xyzal, Zyrtec, Claritin, Chlortrimeton, Benadryl, etc.)

_____ Nasal Sprays (Afrin, Astelin, Astepro, Patanase, Nasonex, Flonase, fluticasone, Nasacort, Rhinocort, Veramyst, etc.)

_____ Breathing Treatments or Nebulizers

_____ Oral or Injectable Steroids (Prednisone, Medrol, Cortisone, Kenalog, etc)

_____ Inhalers, specify _____

_____ Creams (triamcinolone, cortisone, Protopic, Elidel, etc.) _____

_____ Other Medications (Singulair, Xolair, theophylline, etc.) _____

ENVIRONMENTAL HISTORY

1. What type of dwelling does patient live in? House _____ Apartment _____ Trailer _____

2. How old is the dwelling? _____ How many years lived there? _____

3. Is there any free standing water nearby? _____

4. Check those things listed below that apply to your home:

_____ Dehumidifier _____ Central Air Conditioning/heat _____ Air Purifier

_____ Humidifier _____ Pet (s), Specify _____ _____ Problems with Mice

_____ Visible mold or mildew _____ Does anyone you live with smoke? (Even if they smoke outdoors)

_____ Home on a dirt road _____ Do you live on a ranch _____ Woodstove

5. Check any of the following that are in the patient bedroom:

_____ Plastic mattress cover _____ Plastic box spring cover _____ Stuffed toys _____ Curtains

_____ Carpeting _____ Feather Pillow _____ Pets Allowed _____ Books

_____ Air Conditioning _____ Air Vent

Additional notes or concerns:

Back Print

95 Indian Trail Rd

Kalispell | MT 59901-2613

Directions