ADIRONDACK ALLERGY AND ASTHMA ASSOCIATES

TERESE A COPELAND, M.D.

APPOINTMENT REMINDER

WELCOME TO OUR OFFICE

This is a reminder that _____ has an appointment scheduled with Dr. Copeland on _____ at _____.

Please find enclosed a patient questionnaire for you to complete prior to your appointment. Although it may seem lengthy, not all of the sections will apply to you. Please skip over the questions as appropriate. The questionnaire gives you a chance to focus on your symptoms at your leisure before your appointment. Dr. Copeland will discuss your medical history and questionnaire responses in detail during your visit. Please bring your completed questionnaire with you to your appointment. Dr. Copeland will also review any previous medical records that you mail to us or bring to your appointment.

A typical new patient evaluation takes one to two hours depending on the complexity of the problem and the type of testing needed. An appointment time has been reserved for you. **Please call if you need to change the date or time of your appointment.** We require a minimum of two business days notice so that we may offer that appointment to another patient. A fee will be charged if adequate notice is not provided or if the appointment is not kept.

Skin testing is usually done during the evaluation. Please do not take any over the counter antihistamines for at least 7 days, acid reflux medications for 2 days and over the counter sleep aids for 3 days. Asthma inhalers and nasal sprays should be continued. Medications for diabetes, blood pressure and heart problems should also be continued. If you have any questions about a particular medication please call our office.

Please arrive at least 5 to 10 minutes before your scheduled appointment to allow check in. Please remember to bring your completed paper work and your insurance card. Your time is valuable to us and we try to stay on schedule as much as possible.

We look forward to meeting you!

414 Maple Ave, Suite 600 Saratoga Springs, NY 12866 (518) 581-0999/ Fax (518) 581-7098

ADIRONDACK ALLERGY & ASTHMA ASSOCIATES
414 MAPLE AVE SUITE 600
SARATOGA SPRINGS, NY 12866

PATIENT INFORMATION Date: _____ Date of Birth_____ Age: _____

Patient's Name_____ Marital Status_____ Sex _____

Address _____City_____State_____ Zip_____

Home Phone #_____ Cell _____ Work_____

E-Mail _____

Spouse's Name_____

Emergency Contact_____

If patient is a minor, Please fill in the following :
Legal Guardian Name & Date of Birth _____

Relationship to Patient:_____

Address:_____City_____ State_____ Zip_____

Phone #_____
INSURANCE INFORMATION

Primary Insurance_____ Employer_____

Subscriber ID# _____ Group # _____ Co-pay Amount _____

Employee's Name _____ Employee's DOB _____

Secondary Insurance _____ Employer _____

Subscriber ID# _____ Group #_____Co-pay Amount_____

Employee's Name _____Employee's DOB_____

I authorize release of any information necessary to process my insurance claim, assign payments directly to my provider, and acknowledge that I am financially responsible for any unpaid balance. I assign all medical/surgical benefits to Adirondack Allergy & Asthma Associates.

Signature_____Date_____
(of patient or parent/guardian if patient is under 21)

Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Adirondack Allergy & Asthma Associates for services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

Signature_____Date_____

List all names of family, friends or others that we may discuss your Protected Health Information with and include those who may call on your bill:

ADIRONDACK ALLERGY AND ASTHMA ASSOCIATES
Terese A. Copeland, M.D.

NAME: _____ DATE OF BIRTH: _____
FAMILY PHYSICIAN: _____ DATE OF VISIT: _____
REFERRED BY: _____

Please answer the following questions as completely as you can. Not all of the questions will relate to your specific problems. The questionnaire will help us to focus on your needs and concerns.

In your own words, please describe your major symptoms and problems. Please include the duration of the symptoms and what expectations you have of today's visit.

NOSE / SINUS / EYE / THROAT SYMPTOMS:

(please circle and fill in the blanks as appropriate)

NASAL SYMPTOMS: congestion post nasal drainage sneeze itch bleed crusting
drainage: clear /watery thick / discolored
decreased sense of : taste smell

OTHER SYMPTOMS: fever cough bad breath sore throat mouth breathing snore
headache hearing loss ear fullness / ear pain jaw click / clench

INFECTIONS: **sinus:** X Ray / CT done? Date / results:_____
Number of episodes treated with antibiotics per year?_____
ears: Number of episodes treated with antibiotics per year?_____

chest / bronchitis: Have your nasal symptoms led to asthma or bronchitis symptoms in the past? ____ How often ?_____

EYE SYMPTOMS: itch tearing redness puffiness burning discharge dry
Do you wear contact lenses ?_____

DURATION OF SYMPTOMS: _____weeks / months / years

SYMPTOMS OCCUR: daily: AM PM intermittent
year round seasonal
worse with seasons: (circle) **J F M A M J J A S O N D**

CHANGE OF SYMPTOMS: getting better getting worse no change

CHANGE WITH LOCATION: **geographic:** better_____
worse_____

work / school / home: better_____
worse_____

WOMEN (menstrual cycle / pregnancy / menopause): _____
_____

SEVERITY: (circle)

	MILD			**MODERATE**				**SEVERE**	
1	2	3	4	5	6	7	8	9	10

TRIGGERS:

pollen cat dog mold dust mowing / raking smoke perfumes detergents weather humidity illness stress / fatigue foods medications alcohol dampness air conditioning newsprint
other_____

MEDICATIONS:

(Please list the name, dose, frequency, side effects and response to **any prescription, over the counter and herbal medications and nose sprays** that you have used for your nasal, sinus and eye symptoms.)

HAVE YOU CONSULTED OTHER MD's, CHIROPRACTOR OR ALTERNATIVE HEALTH PROVIDER FOR THESE PROBLEMS? Please describe any tests and their results and treatment outcomes. *Please arrange to have these records sent to us before your appointment or bring the records with you.*

CHEST SYMPTOMS:
(Please circle and fill in the blanks as appropriate)

COUGH: dry wet raspy / croupy / deep tight
Stimulated by: exercise laughter crying

CHEST: short of breath tight chest wheeze
trouble getting air in or out

OTHER SYMPTOMS: congestion fatigue snoring heartburn palpitations headache
leg / ankle swelling daytime sleepiness post nasal drainage

DURATION OF SYMPTOMS: _____weeks / months / years

Did symptoms occur after an exposure to : pets pollen / mold
infection chemical / irritant **other**_____

SYMPTOMS OCCUR: daily: AM PM Intermittent
year round seasonal
worse with seasons: (circle) **J F M A M J J A S O N D**

CHANGE OF SYMPTOMS: getting better getting worse no change
work / school / home: better_____
worse_____

WOMEN (menstrual cycle / pregnancy / menopause):_____
_____

	MILD				**MODERATE**				**SEVERE**	
SEVERITY: (circle)	1	2	3	4	5	6	7	8	9	10

TRIGGERS: cold air exercise smoke aerosols dust cat dog mold
pollen weather change illness stress / fatigue laughter crying
foods medications alcohol dampness / humidity menstrual cycle

PLEASE DESCRIBE A "TYPICAL" ATTACK: (*triggers, duration of episode, treatment required, outcome)*

ER VISITS / URGENT VISITS: _____ per year date of last visit:_____
Nebulizer / mist treatments required?_____

HOSPITALIZATIONS: _____per year date of last admission:_____
Usual duration of hospital stay?_____

USE OF ORAL STEROIDS: _____per year date of last use:_____
(prednisone, medrol etc)

DAYS LOST FROM SCHOOL / WORK: _____per year

MEDICATIONS: (Please list the name, dose, frequency, side effects and response to **any prescription, over the counter and herbal medications** that you have used for your chest symptoms.)

HAVE YOU CONSULTED OTHER MD's, CHIROPRACTOR OR ALTERNATIVE HEALTH PROVIDER FOR THESE PROBLEMS? Please describe any tests and their results and treatment outcomes. *Please arrange to have these records sent to us before your appointment or bring the records with you.*

OTHER ALLERGY RELATED SYMPTOMS:

DRUG ALLERGY / SENSITIVITY: Please describe the reaction including the ***name of the medication*** and the ***reason it was given***, ***amount of medication*** that was taken before the reaction occurred, ***types of symptoms*** that resulted, ***type of treatment*** that was needed, ***duration of the reaction*** and ***when*** the reaction last occurred.

FOOD ALLERGY / SENSITIVITY: Please describe the reaction including the ***food*** and the ***way it was prepared***, ***amount of food*** that was eaten before the reaction occurred, ***how long*** it took for the symptoms to occur, ***types of symptoms*** that resulted, ***type of treatment*** that was needed, ***duration of the reaction*** and ***when*** the reaction last occurred.

CONTACT ALLERGY:

Please describe any skin, eye, nose or chest symptoms associated with contact with **metal / jewelry, chemicals / detergents, and cosmetics**.

ECZEMA:

Have you had patches of itchy skin at anytime in your life? Please list medications , soaps and lotions used in the past and your response to treatment.

HIVES / SWELLING:

Please describe your episodes including ***triggers***, ***location*** of the rash, ***duration*** of the hives / welts , ***treatment*** required and ***when*** the last episode occurred. Please **circle** any associated symptoms listed below.

swelling (*lips tongue eyes groin hands feet other*)
tight throat hoarseness short of breath wheeze cough
itch painful swelling joint pain / swelling night sweats fatigue
unexpected hair loss unexpected weight loss fever stomach pain
dry / red eyes temperature change Aspirin/ pain medication
menstrual cycle birthmarks that hive when rubbed bruising
pressure / scratching emotions infections (dental, bladder etc)

STINGING INSECTS:

Please describe any reaction including ***type of insect*** (if known), ***treatment*** required, ***duration*** of reaction and ***when*** the last reaction occurred. Please **circle** any associated symptoms listed below.

itch hives / swelling stomach cramps throat tightness
short of breath cough wheeze loss of consciousness
low blood pressure swelling at sting site only overall flushing

LATEX / RUBBER:

Please describe any chest, eye, nose or skin symptoms noted with protective gloves, balloons, rubber balls, condoms and other products containing rubber / latex. Please note if this is at home or at work.

HEADACHES:

Please describe your types of headaches (migraine, tension, sinus) and **circle** any associated symptoms listed below.

nausea / vomiting vision change loss of consciousness
seizure dizziness bothered by light weakness / numbness

PAST MEDICAL HISTORY: GENERAL HEALTH: excellent good fair poor

PEDIATRIC:
(*if appropriate*)

BIRTH HISTORY: Birth weight _____ Premature?_____
NEWBORN PROBLEMS: (*jaundice, infection, breathing difficulty*)_____
_____

FEEDING: bottle (formula used)_____
breast fed (duration)_____
colicky?_____
IMMUNIZATIONS: up to date missing_____

HOSPITALIZATIONS: (*date, reason, treatment, outcome*) _____
_____
_____

SURGERY: (*date, reason, outcome*)_____
_____
_____

OTHER SIGNIFICANT ILLNESSES:

_____
_____
_____

OTHER MEDICAL PROBLEMS: (*please describe*)

HEAD / EARS / EYES / NOSE / THROAT:

CHEST / LUNG:

HEART DISEASE / BLOOD PRESSURE / CHOLESTEROL:

GASTROINTESTINAL: (*heartburn, reflux ,ulcers, diverticulitis etc*)

URINARY / GYN:

JOINT / MUSCLE:

ENDOCRINE: (*diabetes, thyroid etc*)

SKIN: (*psoriasis, moles and growths, skin cancer etc*)

NEUROLOGIC: (*seizures, strokes, depression, anxiety etc*)

TOBACCO: current use _____packs per day other tobacco products _____per week
past use _____packs per day other tobacco products _____per week

ALCOHOL: _____bottles of beer per week number of alcoholic drinks per week _____

EXERCISE: hours per week _____ type of exercise?_____

SLEEP: number of average hours of sleep when well?_____ when sick?_____

NUTRITION: excellent good fair poor

CURRENT MEDICATIONS: Please list **all** prescription , over the counter and herbal medications, vitamins and dietary supplements and laxatives. (*Include dose and how often it is taken.)*

SOCIAL HISTORY:

MARITAL STATUS_____ EDUCATION LEVEL _____
EMPLOYMENT / OCCUPATION _____
HOBBIES / RECREATIONAL ACTIVITY_____
_____

How has your illness impacted on your life at home and at work? On your family?

FAMILY HISTORY:

RELATIVE	FOOD/MED ALLERGY	NASAL/ SINUS	CHEST/ ASTHMA	DIGESTIVE PROB.	HIVES/ SWELLING	ECZEMA/ SKIN PROB.
MOTHER						
FATHER						
SIBLINGS						
CHILDREN						
OTHER						

ENVIRONMENT: (HOME / WORK)

HOME TYPE: house apartment condo dorm mobile home other

LOCATION: city country mountains river / lake

AGE OF DWELLING: _____ years years occupied ?_____

FLOORING: wood tile / linoleum carpet (*age*)_____

HEATING: hot water electric hot air radiator wood stove other_____

AIR CONDITIONING: none room central

AIR CLEANER / PURIFIER: none room central

BASEMENT: finished unfinished damp / musty dry

OTHER: Do you have a humidifier or dehumidifier? Where is it located?_____

Is there any obvious problem with any of the following in your home?
mold / mildew insects past / current flooding water damage

Are the symptoms worse in any part of the house ? (*garage, attic etc*)
_____

HOUSE PLANTS: number?_____ location?_____

PETS: *Please note the type of pet, number of pets and where they sleep.*
_____

_____

SMOKERS: In the home?_____ Relationship of smoker to patient_____

BEDROOM: dusty cluttered neat toys books / papers
mattress (*age, type*)_____ plastic cover?_____
pillows (*age, type, number, plastic cover*)_____
_____
flooring: wood tile / linoleum carpet (*age*)_____
air conditioning: none room central
air cleaner humidifier ceiling fan window

WORK / SCHOOL: Please note the *age* of the building, *flooring* type, exposures to *mold, dust, animals* or *chemicals* and any other significant factors / concerns.

CHANGE IN SYMPTOMS: Please indicate if your symptoms are different at *home or work*, at a *friend's or relative's home*, on *vacation* or when living in different *geographic areas*. Where are the symptoms better? Worse?