Date of Appointment_____

Patient's First Name_____**Last Name**_____
SSN _____DOB:_____Marital Status: _____ Sex:_____
Email_____ OK to receive email? Yes / No
Residential Address_____(Apt/Unit#)_____
City_____ State_____ Zip_____
Mailing Address if different from residential_____

(Circle preferred number to contact)	Number	OK to leave message with medical information (detailed message)?	OK to receive text messages (appointment reminders)?
Home Phone	_____	Yes / No	
Cell Phone	_____	Yes / No	Yes / No
Work Phone	_____	Yes / No	

Authorized persons that can discuss/obtain my personal health information:
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

Emergency contact #1 _____ Relationship:_____
Home phone: _____ Cell phone: _____ Work phone: _____
Emergency contact #2 _____ Relationship:_____
Home phone: _____ Cell phone: _____ Work phone: _____

Primary Care Physician: _____Phone# _____
Address: _____

Were you referred to Pacific Allergy & Asthma by another provider? Circle: Yes / No
Referring Physician: _____Phone# _____
Address: _____

Or did you hear about us from one of these?
(Circle) Google Facebook Yelp Website Other:_____

Name/Location of Preferred Pharmacy: _____ Phone# _____
Address: _____

Primary Insurance: _____ ID#_____ Group#_____
Address: _____ Phone#_____
Subscriber/Member Name: _____ DOB:_____
Secondary Insurance: _____ ID#_____ Group#_____
Address: _____ Phone#_____
Subscriber/Member Name: _____ DOB:_____

Guarantor/Responsible Party (if patient is under 18 years of age and/or someone else is responsible for payment other than patient):
Name_____ Relationship_____
Address_____
Home phone:_____Cell Phone:_____ Work Phone:_____

Billing Communication:
There may be times when one of our staff members will need to verbally contact patients regarding their account. If we are unable to reach you and get a voicemail prompt, do you authorize us to leave a voicemail?
Circle: Yes / No

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pacific Allergy & Asthma or my insurance company to release any information required to process my claims.

Signature: _____ **Date:** _____
Name: _____

Pacific Allergy & Asthma

Alexander Yu, MD, PhD
5040 SW Griffith Drive, STE 201
Beaverton, OR 97005
Ph: (503)486-4481
Fax: (570)243-0932

Questionnaire

Patient Information:

Name: _____ Today's Date: _____

Medications

Please list all medications you/your child are currently taking:

Drug: _____ Dosage: _____ 1 2 3 Times Daily
Drug: _____ Dosage: _____ 1 2 3 Times Daily
Drug: _____ Dosage: _____ 1 2 3 Times Daily
Drug: _____ Dosage: _____ 1 2 3 Times Daily
Drug: _____ Dosage: _____ 1 2 3 Times Daily
Drug: _____ Dosage: _____ 1 2 3 Times Daily

Known Allergies

Please list all known allergies (environmental, drug, food) as well as the type of reaction and level of severity:

Allergy: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergy: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergy: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergy: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergy: _____ Reaction: _____ Severity: Mild / Moderate / Severe

Surgeries

_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____

Chronic Medical Issues

_____ _____ _____
_____ _____ _____
_____ _____ _____

Pediatric Patients

Full Term: Yes / No Any issues at birth: _____
Formula or Breast milk or Both

Smoking Status

Cigarette/Cigar Smoker Never / Occasional / Weekly / Daily
Chewing Tobacco Never / Occasional / Weekly / Daily

If applicable:

When did you start smoking? _____ Number of packs per day: _____
When did you quit smoking? _____ Total number of years smoking: _____

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Family History

Please list any immediate family history of illness or disease:

Disease/Illness: _____ Relation: _____ Deceased? Yes / No
Disease/Illness: _____ Relation: _____ Deceased? Yes / No
Disease/Illness: _____ Relation: _____ Deceased? Yes / No
Disease/Illness: _____ Relation: _____ Deceased? Yes / No
Disease/Illness: _____ Relation: _____ Deceased? Yes / No
Disease/Illness: _____ Relation: _____ Deceased? Yes / No

Do any IMMEDIATE family members have (circle all that apply):

Asthma Food allergies Immune disease Autoimmune disorders

Environmental Survey

1. Do you live in a house, apartment/duplex, or condominium/townhouse? _____
2. How long have you lived in your home? _____
3. Approximately how old is your home? _____
4. Do you live in a city, suburb, or rural area? _____
5. Do you have air conditioning? Yes / No Window unit / Central Air
6. Type of heating: Hot air Steam/Radiator Electric hot water
7. Do you have (circle all that apply): Wood/coal stove or fireplace, Humidifier, Dehumidifier, Air cleaner/ purifier
8. Pets (number)? Cats ___ Dogs ____ Birds ____ Other _____
9. Do the pets sleep in the patient's room? Yes / No
10. Are there any tobacco smokers in your home? Yes / No.
11. What type of pillows do you or your child use?
12. Cotton, Down, Poly fiber, Memory Foam, Other _____
13. What type of floor covering is there in the bedroom? _____
14. Do you have water leaks, mold contamination? Yes / No
15. Is your home/ apartment excessively humid? Yes / No
16. Do you or your child experience runny nose or sneezing in response to strong odor? Yes / No
17. Do you or your child experience runny nose or sneezing in response to exercise? Yes / No

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1. What symptoms are you/your child experiencing?

_____

_____

2. How often do you or your child experience these symptoms? _____

3. Do you or your child have any of these symptoms?

□ Cough	□ Ear infections	□ Poor sense of smell
□ Runny nose	□ Headaches	□ Hives/swelling
□ Nasal polyps	□ Chest tightness	□ Fatigue
□ Eczema	□ Itchy/watery eyes	□ Blocked ears
□ Wheezing	□ Sinus infections	□Phlegm/sputum (color _____)
□ Nasal congestion	□ Sneezing	□ Other _____
□ Shortness of breath	□ Snoring	
□ Itchy nose	□ Postnasal drip	

4. Which of the following seems to bother or trigger/cause the above symptoms?

□ Grass	□ Smoke	□ Insect bites/stings Describe: _____ _____ _____ _____
□ Cats	□ Humidity	
□ Cosmetics	□ Basements	
□ Drafts	□ Other animals	
□ Nervousness	□ Insecticides	□ Foods List foods and reactions: _____ _____ _____ _____ _____ _____
□ Hay	□ Pollution	
□ Dogs	□ Weather changes	
□ Aerosol sprays	□ Leaves	
□ House dust	□ Latex (rubber)	
□ Cold air	□ Odors	□ Other. List sources and reaction: _____ _____ _____
□ Mold & Mildew	□ Exercise	
□ Horses	□ Perfumes	

5. When are the symptoms worst?
Year round Spring Summer Fall Winter

6. Are symptoms better away from home? Yes / No
If yes, when? _____

7. Have you/your child ever had an allergy test or blood test? Yes / No
If yes, when? _____

8. Have you/your child ever had allergy injections? Yes / No
If yes, when? _____

9. Have you/your child ever used cortisone, prednisone, methylprednisolone, etc. (medications)? Yes / No

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Review of Systems

Please indicate below your history of or current problems by circling YES. If you have never encountered a problem with any of the symptoms below, indicate such with a circle around NO.

General
YES NO Weight gain
YES NO Weight loss
YES NO Fever
YES NO Chills
YES NO Problems sleeping

Head, Eyes, Ears, Nose & Throat
YES NO Change in vision
YES NO Ear infections/ drainage
YES NO Sinus infections
YES NO Problems swallowing
YES NO Glaucoma
YES NO Cataracts
YES NO Impaired hearing

Cardiovascular
YES NO Chest pain
YES NO Shortness of breath
YES NO Heart murmur
YES NO Palpitations
YES NO Fainting

Pulmonary
YES NO Cough
YES NO Shortness of breath
YES NO Sputum production
YES NO Emphysema
YES NO Asthma
YES NO Sleeping during day
YES NO Snoring

Gastrointestinal
YES NO Heartburn
YES NO Change in appetite
YES NO Change in bowel habits
YES NO Black, tarry stool
YES NO Rectal bleeding

Genitourinary
YES NO Pain while urinating
YES NO Burning while urinating
YES NO Blood in urine
YES NO Cataracts

Musculoskeletal
YES NO Arthritis
YES NO Muscle weakness
YES NO Frequent fractures
YES NO Osteoporosis
YES NO Joint stiffness

Neurological
YES NO Strokes
YES NO Seizures
YES NO Depression

Psychiatric
YES NO Depression
YES NO Anxiety
YES NO Other _____

Endocrine
YES NO Hypothyroidism
YES NO Hyperthyroidism
YES NO Diabetes
(Insulin? Yes / No)

Skin
YES NO Rashes
YES NO Jaundice
YES NO Skin cancer
(type:_____)

Other:
_____
_____
_____