

New Patient Information

Thank you for choosing **Central Indiana Allergy**.

In order to provide the most thorough evaluation of your problems, we ask for your assistance with the following items:

- Complete the new patient questionnaire before your appointment.
- Request that copies of pertinent medical records and test results (previous skin tests, X rays, CT scans, pulmonary function tests, and lab tests) be faxed to (317) 865-0056.
- Discontinue antihistamine medications prior to your visit (see attached list for details).
- Allow 3 hours for your initial consultation, exam, and testing.

Please bring your insurance card(s) with you. If your insurance requires a referral, bring the referral form with you or have it faxed to our office. If you have any questions regarding coverage for allergy evaluation or testing, check with your insurance company.

Thank you for your cooperation. If you have questions, please call our office at 865-0055.

CENTRAL INDIANA ALLERGY
5255 E. Stop 11 Rd., Suite 260 · Indianapolis, IN 46237
John E. Duplantier, M.D.
Certified by the American Board of Allergy and Immunology

INSTRUCTIONS FOR NEW PATIENT AND SKIN TEST APPOINTMENTS

Stop using the following antihistamine medications 7 days prior to your appointment:

- Allegra (fexofenadine)
- Astelin (azelastine) nasal spray
- Atarax (hydroxyzine)
- Clarinex (desloratadine)
- Doxepin
- Patanase nasal spray
- Periactin (cyproheptadine)
- Phenergan (promethazine)
- Xyzal
- Zyrtec (cetirizine)
- Loratadine (Claritin, Alavert)

Stop the following antihistamine medications 3 days prior to your appointment:

- Benadryl (diphenhydramine)
- Chlortrimeton (chlorpheniramine)
- “Cough and cold” combination or “Allergy” preparations that contain diphenhydramine or chlorpheniramine
- Allergy eye drops
 - Alomide (Iodoxamide)
 - Elestat (epinastine)
 - Optivar (azelastine)
 - Patanol, Pataday (olopatadine)
 - Zaditor
- Over-the-counter “allergy” eye drops (Visine, Naphcon, ect.)

There is no need to stop the following medications:

- Asthma inhalers
- Singulair (Montelukast)
- Steroid nasal sprays
(Flonase, fluticasone, Flunisolide, Nasacort, Nasarel, Nasonex, Omnaris, Rhinocort, Veramyst)
- Other medications for other medical conditions

CENTRAL INDIANA ALLERGY
5255 E. Stop 11 Rd., Suite 260 · Indianapolis, IN 46237
John E. Duplantier, M.D.
Certified by the American Board of Allergy and Immunology

New Patient Questionnaire

Name: _____ Date of visit: _____

Ref. Physician: _____ Primary Care Physician: _____

Reason(s) for visit: _____

Please check the appropriate space if you have any of the following symptoms or conditions:

Nose: Stiffness Discharge Itching Sneezing Postnasal drainage
 Decreased sense of smell Frequent colds Polyps Nosebleeds Snoring

Sinuses: Headaches Sinus infections

Eyes: Itching Watery discharge Redness Swelling

Ears: Infections Pressure Itching

Chest: Asthma Emphysema/chronic lung disease Tuberculosis Pneumonia
 Coughing Wheezing Shortness of breath Tightness
 Frequent respiratory infections Coughing blood

Do any of the following factors affect your chest symptoms?

Upper respiratory infections Exercise Nighttime Morning Cold air
 Allergens (e.g., dust, animals) Irritants (e.g., smoke, perfume) Acid reflux

Do you have year-round symptoms? Yes No

Please check the appropriate box if any of the following variables make your symptoms worse?

Spring Summer Fall Winter
 Inside Outside Home Workplace
 Exercise Hobbies

Please check the appropriate box if any of the following specific items make your symptoms worse?

House dust Raking Leaves Birds Insect sprays Air pollution
 Turning mattress Mowing grass Cats Scented products Temperature Change
 Basements Hay or Straw Dogs Tobacco smoke Wind
 Feathers Barn dust Horses Newsprint Cold/Heat
 Cottages/cabins Dampness Other Animals Emotional upset Aspirin

Skin: Hives Eczema Itching Skin allergies (e.g., poison ivy, metal)

Suspected food allergy? Yes No

If yes: List suspected foods:

Indicate suspected manifestations:

- Skin Hives Swelling Itching Eczema
Gastrointestinal Vomiting Cramps Diarrhea
Respiratory Swelling of mouth/throat Wheezing/asthma
Anaphylaxis

Past Medical History

Medical Conditions (please list)

Surgeries (please list)

Please list any previous hospitalizations or emergency room visits.

Date Hospital Diagnosis/Treatment

Current Medications:

Medication name and strength	Dose	How many times per day?
------------------------------	------	-------------------------

Please list allergy and asthma medications that you have tried in the past:

Have you ever had allergic reactions to any of the following? If yes please give details.

- Medications
Insect stings (e.g., bees, wasps, hornets, yellow jackets, fire ants)
Latex

If you have had any radiographic studies, please indicate date and facility where these studies were done.

- Chest X-ray
- Chest CT
- Sinus X-ray
- Sinus CT
- Bone density scan
- Other: _____

Have you ever had allergy testing done in the past? Yes No

If yes, indicate approximate date, physician and results.

Environmental History:

In what type of home do you live?

- House Apartment Other (describe): _____

How old is your home? _____ How long have you lived there? _____

Please indicate the location of your home:

- Urban Suburban Rural Wooded Industrial

Smoking in home: No Yes

Heating system: Forced air Other (describe): _____

Air conditioning: Central Room None

Humidifier: Central Room/portable None

Basement: Yes No

If yes, does the basement smell musty? Yes No

Bedroom:

Mattress type: _____

Pillow type: _____

Bedding type: _____

Allergy-proof covers? _____

Flooring type: _____

Pets allowed? _____

Household pets (please types and numbers of pets):

Family History:

Please indicate whether there is a history of asthma, allergic rhinitis (hay fever), sinusitis, eczema, hives, food allergy or recurrent infections/immunodeficiency in any of the following individuals:

Mother:

Father:

Siblings:

Children:

Social History:

Occupation:

Workplace exposures?

If a child

grade in school: _____

Day care attendance?

Marital status: Married Single Divorced Widowed

Children:

Smoking status: Never Current smoker Ex-smoker

If you are a current or ex-smoker, please indicate:

Number of packs per day? _____ Number of years? _____

Any second-hand tobacco smoke exposure?

Alcohol use?

Recreational drug use?

Review of Systems:

General Health: Good Fair Poor Weight loss Weight gain Fevers

Eyes: Glasses Contact lenses Glaucoma Visual impairment

Head/Neck: Migraine headaches Bad breath Nosebleeds Broken nose
 Ringing in ears Hearing impairment Hoarseness

Cardiovascular: Heart murmur Palpitations Chest pain Heart attack
 Blood clots Easy bruising Swelling of legs

Gastrointestinal: Heartburn Difficulty swallowing Vomiting Ulcers
 Pain/cramps Constipation Diarrhea Blood in stool Hepatitis
 Yellow jaundice Pancreatitis Gall bladder problems

Genitourinary: Difficulty urinating Blood in urine Painful urination Incontinence
 Bladder/kidney infections Kidney stones Yeast infections
 Menstrual abnormalities

Skin: Acne Psoriasis Other

Blood/Lymph: Anemia Blood disorder Swollen lymph glands

Cancer: No Yes If yes, list type, site, and current status:

Musculoskeletal: Joint pain Back pain Osteoporosis Rheumatoid arthritis
 Fibromyalgia Lupus Other

Endocrine: Heat/cold intolerance Thyroid disease Diabetes

Neurologic: Stroke Dizziness Numbness Vertigo Tingling
 Extremity weakness Bell's palsy

Psychiatric: Depression Anxiety Mood disorder Schizophrenia
 Suicidal thoughts/attempts Substance abuse
 Other:

Infections: Up to date immunizations Yearly flu immunization Pneumovax
 Recurrent infections (list locations)
 Unusual/opportunistic infections Fungal infections

Entire form reviewed in office on _____ with _____ / _____