

The Allergy and Asthma Center, P.C.

David Mangold, PA-C
Agnieszka Danielewicz, PA-C
20 Four Mile Dr., Suite 2
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. or Agnieszka Danielewicz 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.

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? _____

May we email you with our quarterly newsletter? Circle one, please: Yes No

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

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

Skin

Eczema
 Hives (welts)
 Dryness
 Frequent Rashes

Miscellaneous

Reaction to Insect Bites
 Reaction to Insect Stings

Eyes

Constant Circles
 Redness
 Itching/Rubbing
 Swelling

Ears

Congestion
 Frequent Infections
 Fluid
 Ear Tubes
 Hearing Loss
 Speech Problems

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.) _____

Review of Systems (please circle symptoms that patient had or has now)

General	Weight changes	Fever/chills	Night sweats	Tires easily	Difficulty waking up	
Cardiac	Hypertension	Murmurs	Chest pain	Palpitations	Fainting	
GI	Loss of appetite	Nausea	Difficulty swallowing	Poor weight gain	Vomiting	Greasy Stool
	Diarrhea	Constipation	Heartburn	Indigestion	Abdominal pain	
Urinary	Urgency	Pain w urination	Kidney problems	Blood in urine		
Vascular	Swelling of lower legs	Pain in legs w walking	Varicose veins	Blood clots		
Musculoskeletal	Muscle weakness/pain	Joint pain/stiffness	Joint swelling	Arthritis		
Neurologic	Numbness	Tingling	Headaches	Seizures		
Hematologic	Anemia	Easy bruising				
Endocrine	Heat/cold intolerance	Excessive sweating	Thyroid problem	Diabetes		

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:



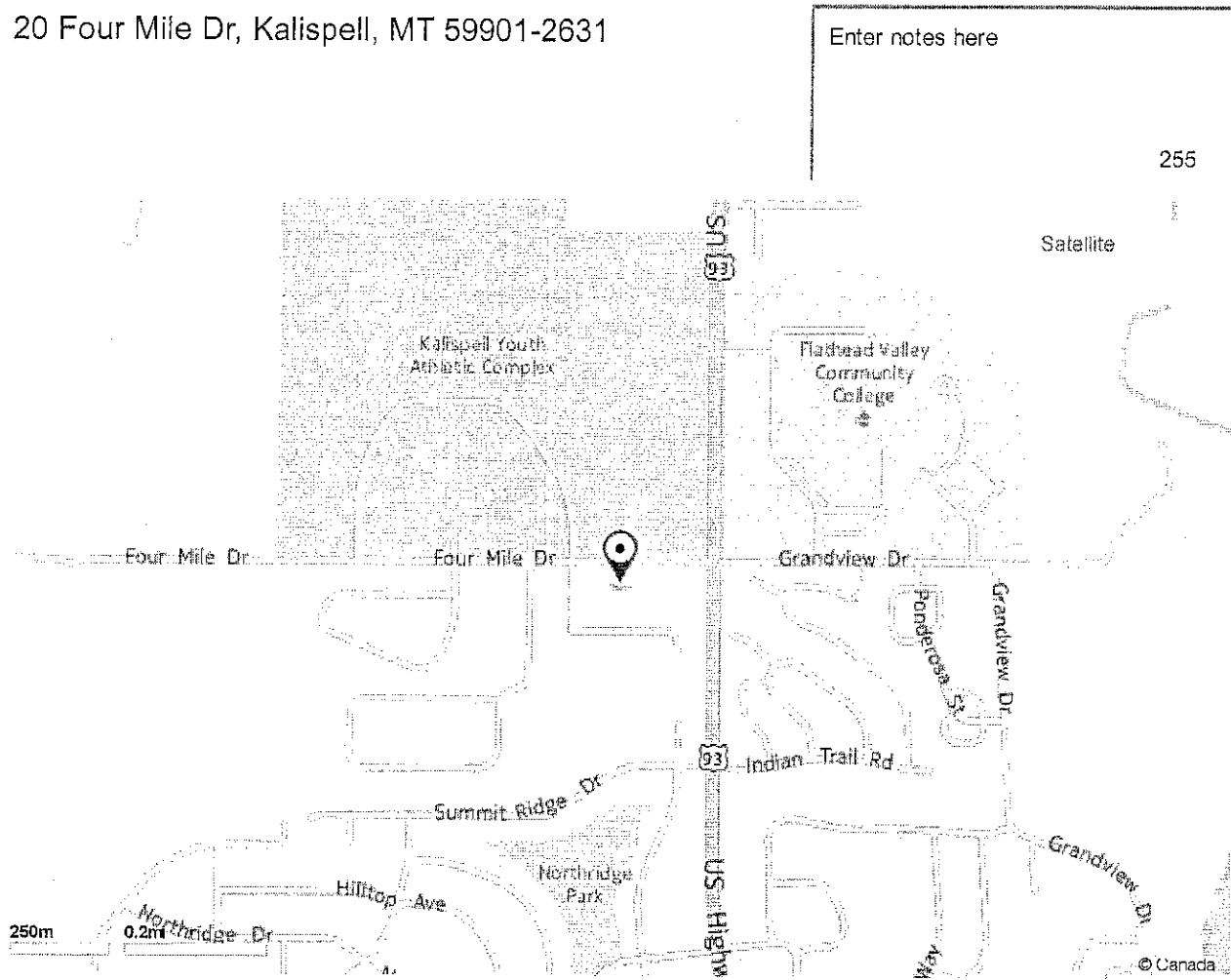
Kalispell Hotel Reviews [TripAdvisor.com/Hotels](https://www.tripadvisor.com/Hotels) Find Kalispell Hotel Deals Save Up To 25% Off On TripAdvisor.

Ad

YAHOO!
MAPS

20 Four Mile Dr, Kalispell, MT 59901-2631

Enter notes here



When using any driving directions or map, it is a good idea to double check and make sure the road still exists, watch out for construction, and follow all traffic safety precautions. This is only to be used as an aid in planning