ALLERGY & ASTHMA CARE OF SAINT LOUIS

☐ MICHELE E. KEMP, M.D.
☐ GARY M. GOODMAN, M.D.
☐ STEPHANIE PARK, M.D.
☐ DOUGLAS R. BERSON, M.D.

1585 Woodlake Dr., Ste. # 201
Chesterfield, MO 63017
Phone: 314-878-2788
Fax: 314-878-8988

8888 Ladue Rd., Ste. # 105
Ladue, MO 63124
Phone: 314-725-8844
Fax: 314-725-8846

Account # _____

PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT'S NAME (Last, First, MI)			SOCIAL SECURITY NUMBER
ADDRESS (Street, Apt. No.)	CITY	STATE	ZIP CODE
PHONE NUMBER / CELL	DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female
MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single			
EMPLOYER NAME			WORK PHONE NUMBER

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN

PHYSICIAN'S NAME	PHYSICIAN'S PHONE NUMBER
PHYSICIAN'S ADDRESS	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY'S NAME	SECONDARY INSURANCE COMPANY'S NAME
CARD HOLDER'S NAME	CARD HOLDER'S NAME
CARD HOLDER'S SOCIAL SECURITY NUMBER	CARD HOLDER'S SOCIAL SECURITY NUMBER
CARD HOLDER'S DATE OF BIRTH	CARD HOLDER'S DATE OF BIRTH

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

NAME (Last, First, MI)			RELATIONSHIP TO PATIENT
ADDRESS	CITY	STATE	ZIP CODE

I understand that Allergy & Asthma Care of St. Louis will file claims to my insurance company as a courtesy to me. I understand that my insurance company may not pay the full amount due. It is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company in a timely manner. **I also understand that co-pays are due at the time of services are provided.** I also agree that if my account is unpaid and must be collected by an outside organization, all costs of collection will also be my responsibility.

I have received and understand the Notice of Privacy Practices provided by Allergy & Asthma Care of St. Louis, describing how medical information about me may be used and disclosed and how I can get access to this information.

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Allergy & Asthma Care of St. Louis.

_____ _____

RESPONSIBLE PARTY'S SIGNATURE **DATE**

ALLERGY & ASTHMA CARE OF SAINT LOUIS

MICHELE E. KEMP, M.D.
GARY M. GOODMAN, M.D.
1585 Woodlake Dr., Ste. # 201
Chesterfield, MO 63017
Phone: 314-878-2788
Fax: 314-878-8988

STEPHANIE PARK, M.D.
DOUGLAS R. BERSON, M.D.
8888 Ladue Rd., Ste. # 105
Ladue, MO 63124
Phone: 314-725-8844
Fax: 314-725-8846

ALLERGY QUESTIONNAIRE

Name _____ Age _____ Date _____

Doctor to whom you would like the report sent: _____

NASAL ALLERGY: ☐ Yes ☐ No ☐ Not Sure. Age of Onset _____ Frequency _____
Seasonal? ☐ Yes ☐ No ☐ Not Sure. Which seasons? _____
Symptoms: ☐ Runny ☐ Stopped up ☐ Sneezing ☐ Post-nasal drainage ☐ Headache ☐ Itching
Worsened by: ☐ damp weather ☐ dust ☐ grass ☐ mildew ☐ spring/fall ☐ outdoors ☐ cats ☐ dogs
Other _____
Do/Did you use nasal drops/sprays? ☐ Yes ☐ No. Which kind? _____

COUGH: ☐ Yes ☐ No. Age of onset _____ ☐ Daily ☐ Intermittently (how frequent) _____ ☐ Rarely
☐ Seasonal ☐ Year-round. ☐ Dry ☐ Wet. Limits activity? ☐ Yes ☐ No. Awakes from sleep? ☐ Yes ☐ No
Associated with: ☐ Difficulty breathing ☐ Wheeze ☐ Post-nasal drainage ☐ Chest pain ☐ bad taste
Triggers: ☐ pollen ☐ pets ☐ smoke ☐ exercise ☐ strong odors ☐ eating
Medicines tried _____

ASTHMA: ☐ Yes ☐ No ☐ Not Sure. Age of onset _____ ☐ Seasonal ☐ Year-round
Symptoms: ☐ Cough ☐ Wheeze ☐ Difficulty breathing ☐ Exercise limitation ☐ Poor sleep
Worsened by: ☐ infections ☐ exercise ☐ laughing ☐ cold air ☐ smoke ☐ strong odors ☐ dust
☐ grass ☐ pets ☐ pollution ☐ aspirin ☐ foods ☐ drugs ☐ damp weather
Other _____
Time of day most affected: ☐ wake-up ☐ late AM ☐ early PM ☐ late PM ☐ no pattern
Medicines tried _____

RECURRENT INFECTIONS: ☐ Yes ☐ No ☐ Not sure
Ear infections: ☐ Yes ☐ No. Tubes in ears? ☐ Yes ☐ No. Dates _____
Sinus infections: ☐ Yes ☐ No. Previous X-rays/CT scans? ☐ Yes ☐ No. Dates _____
Are infections seasonal? ☐ Yes ☐ No. Antibiotics tried? _____
Symptoms _____

SKIN ALLERGY: ☐ Yes ☐ No ☐ Not sure. Present or past? (circle one)
Hives: ☐ Yes ☐ No. Eczema: ☐ Yes ☐ No. Rash: ☐ Yes ☐ No. Describe _____
Approximate date of onset: _____ Frequency _____
Suspected causes _____

INSECT STING ALLERGY: ☐ Yes ☐ No ☐ Not sure. Which insect? _____
Symptoms _____
Date of onset: _____ Frequency of episodes _____

FOOD/GASTROINTESTINAL ALLERGY: ☐ Yes ☐ No ☐ Not sure
Symptoms _____
Age of onset _____ Frequency of episodes _____
Suspects: _____

FAMILY HISTORY:
Allergies ☐ Yes ☐ No. Who? _____ Eczema ☐ Yes ☐ No. Who? _____
Asthma ☐ Yes ☐ No. Who? _____ Sinus ☐ Yes ☐ No. Who? _____
Other family health problems _____

EARLY CHILDHOOD HEALTH: (only for patients under 18 years of age)

Birthweight _____ Complications? _____

Problems in infancy: ☐ Colic ☐ Milk intolerance ☐ Ear infections Other _____

Infant diet: Breastfed ☐ Yes ☐ No. Duration _____ Formula ☐ Yes ☐ No. Which _____

HOME / ENVIRONMENT:

Do you smoke? ☐ Yes ☐ No. Do family members smoke? ☐ Yes ☐ No

Age of residence? _____ Type of residence? ☐ Apt. ☐ Home Other _____

Basement? ☐ Yes ☐ No. Carpet ☐ Yes, how old? _____ ☐ No. Bedroom rugs? ☐ Yes ☐ No

Forced air/heating? ☐ Yes ☐ No. Central air? ☐ Yes ☐ No. Dust mite covers? ☐ Yes ☐ No

Pets? ☐ Yes ☐ No. Describe _____

Occupation (self and/or immediate family members) _____

Hobbies: _____ Child care arrangements: ☐ day care ☐ home ☐ babysitter

GENERAL HEALTH:

Daily medicines _____

Occasional medicines _____

Medication allergies _____

Previous skin tests: ☐ Yes ☐ No. Other tests (sweat test, Chest X-ray, etc.) _____

Other medical problems _____

Hospitalizations/surgeries _____

missed school/work days in last year _____ Planning pregnancy? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No. If quit, when _____ # drinks/day _____

Do you smoke? ☐ Yes ☐ No. If quit, when _____ # cigarettes/day _____

SYSTEM REVIEW: Check all applicable symptoms. If not applicable, check N/A.

General: ☐ Recent weight change ☐ Fever ☐ Fatigue/Weakness ☐ Chills ☐ Night sweats ☐ N/A

Eyes: ☐ Vision changes (circle) L R Both ☐ Pain (circle) L R Both ☐ Burning (circle) L R Both
☐ Discharge (circle) L R Both ☐ Double vision (circle) L R Both ☐ N/A

Ears, Nose, Mouth, Throat: ☐ Ringing in ears ☐ Hearing loss ☐ Earache ☐ Discharge from ear
☐ Itchy ears ☐ Dizziness ☐ Popping ears ☐ Stuffy nose ☐ Nasal discharge ☐ Post nasal drip
☐ Sneeze ☐ Snoring ☐ Headache ☐ Loss of smell/taste ☐ Nosebleed ☐ Mouth sores
☐ Dental problems ☐ Difficulty swallowing ☐ Voice changes ☐ Sore throat ☐ N/A

Cardiovascular: ☐ Chest pain ☐ Irregular heart beat ☐ Palpitations ☐ Dizziness ☐ Leg swelling
☐ Leg pain with walking ☐ N/A

Lungs: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Mucus production ☐ Cough up blood ☐ N/A

Gastrointestinal: ☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn/indigestion ☐ Cramps
☐ Loss of appetite ☐ Food intolerance (specify) _____ ☐ N/A

Musculoskeletal: ☐ Joint pain ☐ Joint swelling ☐ Muscle pain ☐ N/A

Neurologic: ☐ Headache ☐ Numbness/tingling ☐ Blackouts ☐ Seizures ☐ Paralysis ☐ Tremor ☐ N/A

Psychiatric: ☐ Depression ☐ Anxiety ☐ N/A

Endocrine: ☐ Thyroid issues ☐ Heat/cold intolerance ☐ Excessive sweating ☐ Excessive urination
☐ Excessive hunger ☐ Unexplained weight gain/loss ☐ N/A

Genitourinary: ☐ Frequent urination ☐ Painful urination ☐ Blood in urine ☐ Incontinence
☐ Difficulty urinating ☐ Frequent urinary tract infections ☐ N/A

Blood: ☐ Easy bruising ☐ Easy bleeding ☐ Clotting disorder ☐ N/A

Skin: ☐ Rash ☐ Hives ☐ Itching ☐ N/A

Other: _____

Is there anything else you would like to discuss? _____

Additional physician notes:

Initial assessment reviewed by physician _____ Physician Signature _____ Date

ALLERGY & ASTHMA CARE

OF SAINT LOUIS

Infants ~ Children ~ Adults

Michele E. Kemp, M.D. • Gary M. Goodman, M.D. • Stephanie Park, M.D. • Douglas R. Berson, M.D.

PRIVACY CONSENT

I, _____, give my consent for Allergy & Asthma Care of St. Louis to share my personal health information with the following people and to receive information from this person on my behalf. This is for the purpose of expediting treatment, lab/test results or insurance issues. **PLEASE PROVIDE NAME AND RELATION AS WELL AS CONTACT NUMBER.**

1. _____ **Phone:** _____
2. _____ **Phone:** _____
3. _____ **Phone:** _____
4. _____ **Phone:** _____
5. _____ **Phone:** _____

Preferred Electronic Communications

☐ Email: _____

☐ Text Message: _____

May we leave a message on voicemail

☐ Home	Y	N
☐ Mobile	Y	N
☐ Work	Y	N

Signed: _____ Date: _____

Diplomates of the American Board of Allergy and Immunology

1585 Woodlake Dr., Ste. # 201
Chesterfield, MO 63017
Phone: 314-878-2788
Fax: 314-878-8988

8888 Ladue Rd., Ste. # 105
Ladue, MO 63124
Phone: 314-725-8844
Fax: 314-725-8846

POS Reorder # 1619748