

ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES OF TAMPA BAY

www.allergytampa.com

RICHARD F. LOCKEY, M.D. ROGER W. FOX, M.D. DENNIS K. LEDFORD, M.D. MARK C. GLAUM, M.D., Ph.D.

Please complete front and back of form.

DATE _____ SOCIAL SECURITY # _____

PATIENT'S NAME _____ CIRCLE: MR. MRS. MS. MISS

CIRCLE: MALE / FEMALE DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

STREET ADDRESS & APT. # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # () _____ CELL # () _____ DRIVER'S LICENSE # _____

E-MAIL ADDRESS _____

PATIENT'S PLACE OF EMPLOYMENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK TELEPHONE # () _____ EXT. # _____

(IF PATIENT IS UNDER 18, PLEASE COMPLETE)

PARENT OR GUARDIAN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME TELEPHONE # () _____ WORK TELEPHONE # () _____

PRIMARY CARE PHYSICIAN _____ TELEPHONE # () _____

PRIMARY PHYSICIAN'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____

TELEPHONE # () _____

RELATIONSHIP TO YOU _____

WORK TELEPHONE # () _____

Present all insurance / pharmacy cards to the receptionist.

INSURANCE # 1 - PRIMARY

NAME OF INSURANCE CO. _____

HMO PPO OTHER _____

CO. ADDRESS _____

PHONE # _____

MEMBER # _____

GROUP # _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SSN _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S DATE OF BIRTH _____

COPAY OR PERCENTAGE OF AMOUNT _____

INSURANCE # 2 - SECONDARY

NAME OF INSURANCE CO. _____

HMO PPO OTHER _____

CO. ADDRESS _____

PHONE # _____

MEMBER # _____

GROUP # _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SSN _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S DATE OF BIRTH _____

COPAY OR PERCENTAGE OF AMOUNT _____

*Please Note That Workers' Compensation Cases must Be Preauthorized by Management.

over →

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If you have a medication prescription plan, please complete:

Name of pharmacy company _____

ID# _____ Phone # _____

AUTHORIZATIONS

1. CONSENT FOR MEDICAL TREATMENT: I AUTHORIZE ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY (AAIATB) TO FURNISH THE NECESSARY MEDICAL TREATMENTS, PROCEDURES, DRUGS, AND SUPPLIES AS ORDERED. I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT, DIAGNOSTIC PROCEDURES, AND EXAMINATIONS.
2. STATEMENT OF FINANCIAL RESPONSIBILITY: I HEREBY AGREE TO PAY AAIATB FOR ALL CHARGES (TO INCLUDE CO-PAYS, DEDUCTIBLES, PERCENTAGES, AND HEALTH SAVINGS ACCOUNTS) AT THE TIME OF SERVICE; HOWEVER, I UNDERSTAND THAT AAIATB MAY ACCEPT ASSIGNMENT OF INSURANCE BENEFITS IN LIEU OF EQUAL AMOUNT OF PAYMENT. THE FULL AMOUNT OF ALL CHARGES NOT PAID BY THE INSURANCE COMPANY WILL ULTIMATELY BE MY RESPONSIBILITY. I REALIZE THAT IF A BALANCE IS DUE NECESSITATING THE USE OF A COLLECTION AGENCY, I AGREE TO PAY ALL COLLECTION COSTS, INCLUDING ATTORNEY FEES AND FEES ON APPEAL.
3. OUR BILLING AND COLLECTION PROCEDURES REQUIRE THAT THE SOCIAL SECURITY NUMBER OF THE INSURED/RESPONSIBLE PARTY BE PROVIDED.
4. NOTICE OF PRIVACY OF PROTECTED HEALTH INFORMATION RECEIVED AND CONSENT IS GIVEN TO RELEASE MEDICAL RECORDS TO OTHER HEALTH CARE PHYSICIANS.

WELCOME, WHY DID YOU SELECT OUR PRACTICE? (Complete as applicable)

- REFERRED BY DR. _____ REFERRED BY MY INSURANCE COMPANY
- REFERRED BY ANOTHER PATIENT _____ ADVERTISEMENT (circle one) our website / phonebook / internet

DATE _____ PATIENT OR GUARDIAN'S SIGNATURE _____

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY

Richard F. Lockey, M.D.
Roger W. Fox, M.D.
Dennis K. Ledford, M.D.
Mark C. Glaum, M.D., Ph.D.
13801 Bruce B. Downs Boulevard, Suite 502
Tampa, Florida 33613 - (813) 971-9743
Billing: Ext. 111
www.allergytampa.com

FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we will work with you. The following information is provided to help avoid any misunderstandings about the bill for professional services rendered.

- Our office participates in a variety of insurance plans. **It is your responsibility to:**
 - **Bring your insurance card at each visit.**
 - **Be prepared to pay your co-pay, deductible, or co-insurance at the time services are rendered, to include high deductible health plans (HSA). Payment can be made by cash, check, or we accept Visa and Master Card.**
 - **Payment in full is expected at the time services are rendered.**
- If you have insurance with which we are not contracted, we will file the claim if you have out-of-network benefits, any deductible or co-insurance that you are responsible for is due at the time of service. If your insurance does not provide out-of-network benefits, then you are responsible for payment in full.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance based on hardship guidelines. Please so inform us prior to your visit. Financial hardship cases are for patients without medical insurance.
- Referrals: It is your responsibility to provide required referrals prior to the visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible for payment in full.
- If the patient is 18 years or younger, the patient’s legal guardian must sign below. When a minor is seen, all the same rules and regulations apply.
- A \$50.00 charge is assessed to patients who do not cancel a scheduled appointment within 48 hours or do not come for their visit (no-shows).

Our practice firmly believes that a good physician/patient relationship is based on understanding and good communications. Questions about financial arrangements should be directed to the front office.

Signature of Patient or Responsible Party

Date

Signature of Co-Responsible Party

Date

Richard F. Lockey, M.D.
Roger W. Fox, M.D.
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Mark C. Glaum, M.D., Ph.D.

Adult and Pediatric
Allergy, Asthma and Immunology

Diplomates American Board
of Allergy and Immunology

13801 Bruce B. Downs Blvd.
Suite 502
Tampa, FL 33613
813/971-9743

ACKNOWLEDGMENT

I, (print patient's name) _____, acknowledge that I have received a copy of the Notice Regarding Privacy of Personal Health Information from Allergy, Asthma and Immunology Associates of Tampa Bay.

Patient's Signature

Date

BP _____	P _____	R _____
Height _____	Weight _____	

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY

Richard F. Lockett, M.D.

Roger W. Fox, M.D.

Dennis K. Ledford, M.D.

Mark C. Glaum, M.D., Ph.D.

13801 Bruce B. Downs Boulevard, Suite 502

Tampa, Florida 33613 - (813) 971-9743

www.allergytampa.com

MEDICAL HISTORY AND ALLERGY SURVEY

NAME _____ AGE _____ DATE _____

NAME OF PERSON COMPLETING FORM IF NOT COMPLETED BY PATIENT _____

NAME OF PRIMARY CARE PHYSICIAN (PCP) _____

NAME OF REFERRING PHYSICIAN (IF OTHER THAN PCP) _____

INSTRUCTIONS: YOU MUST COMPLETE THIS FORM. OUR INSURANCE REQUIRES THAT IT BE DONE. YOU WILL NOT BE SEEN UNLESS IT IS COMPLETED. THERE ARE 8 PAGES. PLEASE COMPLETE ALL PAGES.

Circle the allergy problems that you have now:

- | | | | |
|-----------------------|------------|--------------------|------------------|
| (1) Hay fever/sinus | (3) Hives | (5) Insect allergy | (7) Drug allergy |
| (2) Asthma/bronchitis | (4) Eczema | (6) Food allergy | (8) Headache |

I. CLINICAL HISTORY

- A. Describe your major allergy symptoms. How do they make you feel? What makes your symptoms worse or better?

- B. What are your expectations from this allergy consultation?

- C. Current medications. (Please list all of your medications, prescribed and over-the-counter, including aspirin, laxatives, sleeping medicines, and nutritional supplements)

- D. List all drug allergies. (Please list name of drug, type of reaction, and approximate date of reaction)

CONTINUE TO NEXT PAGE

II. SYMPTOMS (grade: none 0, mild 1, moderate 2, severe 3, or ✓ if you experience these symptoms)

Eyes: Itching___ Swelling___ Burning___ Tearing___ Discharge___

Ears: Itching___ Fullness___ Popping___ Decreased hearing___ Pain___

Nose: Sneezing___ Itching___ Runny nose___ Mouth breathing___ Snoring___

Nasal obstruction___ Discolored discharge___ Color___ Sense of smell impaired___

Headache___ Where?_____

How often?_____ How severe?_____

Throat: Itching___ Soreness___ Post nasal drip___ Throat clearing___ Swelling___ Enlarged glands___

Chest: Cough___ Sputum___ Color and amount_____

Wheezing___ Chest tightness___ Cough with exercise___

History of asthma diagnosed by physician___ What age?_____

History of hospitalization for asthma Yes___ No___

History of emergency room visit for asthma Yes___ No___

Caused by infection___ Caused by allergy___

Exercise-induced asthma___ Nighttime wheezing___

Skin: Dermatitis___ Eczema___ Hives___ Swelling___ Rashes___

Where on your body now? _____

- A. Age of onset of your respiratory allergies (hay fever and/or asthma) _____
- B. Do you have daily symptoms? _____
- C. Do you have seasonal symptoms? _____
- D. Are you having more allergy problems recently? _____
- E. What time of the year are your allergies worse? (Please list months.)

- F. What time of day or night is the worst time according to you?

- G. Does any particular exposure (cat, dust, smoke) make you much worse?
(Please list.) _____
- H. Please list all food allergies. _____
History of milk allergy as an infant? _____
- I. Have you had a life threatening allergic reaction to a stinging insect (bee, wasp, yellow jacket, hornet, fire ant)? _____
- J. Have you had hives previously? _____

- K. Have you had hives lasting for more than 6 weeks previously? _____
- L. Have you ever had or do you have eczema (also called atopic dermatitis)? _____

III. PREVIOUS ALLERGY EVALUATION AND TREATMENT

- A. Name of allergist and city _____
- B. Please list your allergies (confirmed by skin test or blood test) _____

- C. Have you received allergy shots? _____
Were allergy shots beneficial? _____
How long were you on allergy shots? _____
When was your last allergy shot? _____
- D. Is your home environment allergy-free? _____
- E. Please list or circle all medications, prescribed or over-the-counter drugs, you have used to treat your allergies.

Allergy Medications:

Antihistamines

Benadryl, Allegra, Zyrtec, Claritin, Alavert, Clarinex, others _____

Antihistamine/Decongestants

Allegra-D, Claritin-D, Clarinex-D, Zyrtec-D, Allerx-D, others _____

How often do you use? _____

improved _____ not improved _____ adverse reactions _____

Was one best overall? _____ Worst overall? _____

Nasal Sprays

Cromolyn (Nasal crom), Atrovent, Astelin, others _____

Nasal Sprays (Steroid)

Flonase, Nasacort AQ, Rhinocort AQ, Nasalide, Nasarel, Nasonex, others _____

How often do you use? _____

improved _____ not improved _____ adverse reactions _____

Was one best overall? _____ Worst overall? _____

Asthma Medications:

Metered Dose Inhalers

Ventolin or Proventil (albuterol), Maxair Autohaler, Serevent (salmeterol), Foradil, Atrovent, Combivent, Spiriva, Aerobid, Azmacort, Pulmicort, Flovent (44 mcg, 110 mcg, 220 mcg), Advair (100/50 mcg, 250/50 mcg, 500/50 mcg), QVAR (40 mcg, 80 mcg)

Nebulizer

Ventolin or Proventil (albuterol), Xopenex, Pulmicort

How often do you use? _____

improved _____ not improved _____ adverse reactions _____

Was one best overall? _____ Worst overall? _____

Oral Medications:

Theophylline: Uniphyl

Leukotriene antagonist: Singulair, Accolate, Zflo

Proventil/Ventolin syrup or tablets

Prednisone, Medrol, Orapred, Prelone, Pediapred

How often do you use? _____

improved ___ not improved ___ adverse reactions _____

Was one best overall? _____ Worst overall? _____

Last date on prednisone _____

Antibiotics for bacterial infections (sinusitis, bronchitis, pneumonia):

Name _____ How often do you use? _____

improved ___ not improved ___ adverse reactions (rash) _____

Name _____ How often do you use? _____

improved ___ not improved ___ adverse reactions (rash) _____

Name _____ How often do you use? _____

improved ___ not improved ___ adverse reactions (rash) _____

Last date on antibiotics _____

Injection

Xolair

How often do you use? _____

When started _____

improved ___ not improved ___ adverse reactions _____

IV. PAST MEDICAL HISTORY

- A. With the patient's permission, the doctor would like to review your previous medical records. Are any available?

Yes ___ No ___

Name: Hospital _____ Doctor _____ Lab / X-rays _____

- B. Please list all operations, illnesses, injuries, surgery, and other significant hospitalizations you have had, even unrelated to your allergy problem.

1. All operations: _____

2. Current medical problems that require treatment: _____

3. Prior medical problems: _____

4. Any other hospitalizations/emergency room visits: _____

CONTINUE TO NEXT PAGE

- C. Have you been hospitalized for asthma? _____ When? _____

Have you required emergency room visits or emergency treatment by your physician for asthma?

- D. Do you have any current medical problems or a history of any medical problems?
 Diabetes_____ Thyroid disorder_____ High blood pressure_____ Seizures _____
 Arthritis_____ Hepatitis_____ Ulcers_____ Heartburn/reflux_____ Other _____
- E. Have you ever had a blood transfusion?_____ When? _____
- F. Have you experienced recurrent sore throats, repeated sinus infections (how often? _____; documented by x-ray? _____), or severe infections (what kind, kidney infection _____, meningitis _____, or pneumonia? _____), when? _____
- G. Have you had nasal polyps, adverse reaction to aspirin, or sinus surgery?

- H. Do you have any other symptoms or complaints?

- I. Have you had a chest x-ray, sinus x-ray, lung function tests, EKG, blood tests? Please comment on the results.

- J. Are your vaccinations up to date?_____ Tetanus? (every 10 years) _____
- K. Do you receive the flu vaccine yearly? _____
- L. Have you received the Pneumovax (for pneumonia)? _____ When? _____
- M. Complications from your birth? _____
- N. Complications from the birth of your children? _____

V. ENVIRONMENTAL HISTORY

- A. Do your symptoms occur around any specific environment, exposure, location, or activity (for example, lawn mowing, animals, dusty environments, old leaves, strong odors, exercise)?

- B. Do you suspect that anything in your home, work place, or other locations cause your symptoms?

- C. What type of home do you have and what is the surrounding area like (suburbs, country)?

 How long have you lived in your current residence? _____
- D. Do you have indoor animals or bird? Please list. _____
- E. Do you have a feather, foam, or Dacron pillow? _____
- F. Do you have a new or old mattress? _____ Or, a waterbed? _____
- G. Do you have wall-to-wall carpeting throughout your home? _____
- H. Are your windows opened or closed most of the time? _____
- I. Do you have central air conditioning? _____
- J. Does air conditioning help your symptoms? _____

CONTINUE TO NEXT PAGE

- K. Do your symptoms become better or worse on vacations, trips, or at the beach? _____
- L. Do you have symptoms after eating at home or in a restaurant? _____
- M. Does a change in the weather influence your allergic symptoms? _____
- N. Do strong odors, powders, fumes, cigarette smoke make you worse? _____
- O. How do strenuous activities affect your symptoms? _____
- P. How many other people live in your home? _____
Do any of them smoke? _____

VI. PERSONAL AND SOCIAL HISTORY

- A. Do you presently smoke (how much and how long)? _____
- B. Have you ever smoked and when did you quit? _____
- C. How much alcohol do you drink? _____
- D. Do you use recreational drugs? (This is confidential.) _____
- E. Do you consider yourself at risk for HIV? _____
- F. What is your occupation? _____
What are your daily activities? _____
How many days have you missed from work or school? _____
- G. Are you exposed to any toxic chemicals, noxious substances, or cigarette smoke? _____
- H. How long have you lived in Tampa and/or Florida? _____
- I. Where have you lived previously? _____
- J. Are you happy with your life? If not, why? _____
- K. Marital status (if applicable) _____
- L. In which type of exercise do you participate? _____
How often? _____

VII. FAMILY HISTORY

Anyone in your family with allergies? Yes _____ No _____

Is your father alive? _____ Age _____ Cause of death and age at death if deceased _____

Is your mother alive? _____ Age _____ Cause of death and age at death if deceased _____

Brothers/Sisters:

_____	Age _____	Medical Illness? _____
_____	Age _____	Medical Illness? _____
_____	Age _____	Medical Illness? _____
_____	Age _____	Medical Illness? _____
_____	Age _____	Medical Illness? _____

Children:

_____	Age	_____	Medical Illness?	_____
_____	Age	_____	Medical Illness?	_____
_____	Age	_____	Medical Illness?	_____
_____	Age	_____	Medical Illness?	_____
_____	Age	_____	Medical Illness?	_____

A. Have any blood relatives had:

_____ Arthritis	_____ TB	_____ Stroke	_____ Diabetes
_____ Asthma	_____ High blood pressure	_____ Systemic lupus erythematosus	_____ Gout
_____ Hay fever	_____ Heart disease	_____ Scleroderma	_____ Back trouble

B. Are there any hereditary diseases or other disorders that seem to occur frequently in your family (diabetes, emphysema, heart problems)?

VIII. REVIEW OF SYSTEMS Do you have any of the following? (Check)

General

_____ change in weight
 _____ how much? _____
 _____ chills
 _____ fevers
 _____ loss of appetite
 _____ dry mouth
 _____ sleep disturbed by your snoring

Nose and Throat

_____ frequent sneezing
 _____ continuously runny, stuffy nose
 _____ recurrent sore throat
 _____ dentures
 _____ hay fever
 _____ sinus infections

Eyes

_____ dry eyes
 _____ itchy eyes
 _____ change in vision
 _____ glaucoma
 _____ cataracts
 _____ contact lenses

Ears

_____ trouble hearing
 _____ ringing in ears
 _____ earache
 _____ discharge from ears

Skin

_____ skin rashes
 _____ recurrent skin infections
 _____ lump or growth
 _____ skin cancer
 _____ chronic skin condition

Gastrointestinal

_____ nausea
 _____ vomiting
 _____ diarrhea
 _____ change in bowel habits
 _____ trouble swallowing
 _____ heartburn
 _____ black or bloody bowel movements

Cardiovascular

_____ chest pain
 _____ chest pain with exercise
 _____ calf pain with exercise
 _____ ankle swelling
 _____ shortness of breath
 _____ sleep on 2 or more pillows
 _____ heart murmur
 _____ heart attack
 _____ palpitations
 _____ mitral valve prolapse
 _____ high blood pressure
 _____ high cholesterol

Kidney

_____ trouble starting urine
 _____ bed wetting
 _____ burning with urination
 _____ loss of urine with cough or sneeze
 _____ frequent urination during the night
 _____ painful urination
 _____ blood in urine
 _____ kidney stones
 _____ gonorrhea/syphilis
 _____ genital herpes

Blood

- had anemia
 bleed or bruise easily
 swollen lymph nodes
 blood transfusion

Musculoskeletal

- morning joint stiffness & aching
 painful, swollen joints
 muscle tenderness or pain
 muscle weakness

Endocrine

- cold intolerance
 heat intolerance
 increased thirst
 frequent urination
 diabetes
 thyroid disease

Gynecological (female)

- excess bleeding
 vaginal discharge
 change in menstrual cycle

Date of last PAP smear _____

Date of last mammogram _____

Male

Date of last PSA test _____

Neurological and Psychological

- weakness/clumsiness
 tingling, burning, or numbness of extremities
 frequent or severe headache
 dizziness
 fainting
 stroke
 epilepsy
 nervous breakdown
 depression
 lack of energy
 anxiety
 fearful, anxious
 excessive worry
 crying spells
 trouble sleeping
 behavior problems

Other

- lumps, bumps under arms or breasts
 skin rashes in the groin
 skin rashes between legs
 skin rashes on the toes
 skin rashes on the feet

Sleepiness Scale - Are you sleepy during the day? If so, complete the following using the appropriate numbers.

- 1 = slight chance of dozing
 2 = moderate chance of dozing
 3 = high chance of dozing

Chance of dozing

- _____

Situation of dozing / falling asleep

- Sitting and reading
 Watching television
 Sitting inactively in a public place (such as a theater or meeting)
 As a passenger in a car for an hour without a break
 Lying down to rest in the afternoon when circumstances permit
 Sitting and talking to someone
 Sitting quietly after lunch without alcohol
 In a car, while stopped for a few minutes in traffic

Have you seen any doctors in the last 6 months? _____

To the best of my knowledge, I have answered the complete questionnaire.

Reviewed form with patient in its entirety.

Signature

Roger W. Fox, M.D. / Dennis K. Ledford, M.D.

ASTHMA CONTROL TEST (ACT)

This form must be completed by the patient to comply with insurance requirements / documentation.

Please circle **ONE** answer for each of the **5** questions below and review your results with your physician.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work or at home?

All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5
-----------------	----------	------------------	----------	------------------	----------	----------------------	----------	------------------	----------

2. During the past 4 weeks, how often have you had shortness of breath?

More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5
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3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night, or earlier than usual in the morning?

4 or more nights a week	1	2 to 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5
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4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	1	1 to 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5
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5. How would you rate your asthma control during the past 4 weeks?

Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5
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TOTAL SCORE _____ (please enter score on the other side of this form)

If your total score is 19 or less, your asthma may not be as well controlled as it could be.

YOU MAY PRINT THIS FORM PRIOR TO YOUR VISITS BY ACCESSING

www.allergytampa.com/medlist

THIS FORM MUST BE COMPLETED BY THE PATIENT BEFORE SEEING THE DOCTOR TO COMPLY WITH INSURANCE REQUIREMENTS / DOCUMENTATION

____ RICHARD F. LOCKEY, M.D.

____ ROGER W. FOX, M.D.

____ DENNIS K. LEDFORD, M.D.

____ MARK C. GLAUM, M.D., Ph.D.

PATIENT'S NAME _____ DATE _____

CHIEF COMPLAINT: _____

And/or circle items if applicable: Routine visit Need refills Sneezing Runny nose Itchy eyes Cough Wheeze Asthma Respiratory infection Sinusitis Headache Fever Earache Discolored discharge

NEW PROBLEMS SINCE LAST VISIT: _____

PREVIOUS PROBLEMS: STABLE _____ OR WORSENING (describe) _____

LIST ALL MEDICATIONS AND THE DOSE PRESCRIBED TO YOU BY ALL PHYSICIANS WHICH YOU TAKE. NOTE: WE CAN ONLY REFILL MEDICATIONS PRESCRIBED TO YOU BY US.

<u>MEDICATION</u>	<u>DOSE</u>	<u>TIMES TAKEN IN A DAY</u>	<u>✓ REFILLS (only if needed)</u>
1) _____			
2) _____			
3) _____			
4) _____			
5) _____			
6) _____			
7) _____			
8) _____			
9) _____			
10) _____			

PRESCRIPTIONS ARE HANDWRITTEN TO TAKE TO YOUR PHARMACY OR MAIL ORDER. WE DO NOT CALL IN OR FAX PRESCRIPTIONS FROM OUR OFFICE.

IF YOU MAIL YOUR PRESCRIPTIONS, DOES YOUR INSURANCE REQUIRE A 90 DAY SUPPLY ? _____ OR, DO YOU FILL YOUR PRESCRIPTIONS AT A LOCAL PHARMACY ? _____

ANY ALLERGIES TO MEDICATIONS _____

have asthma? complete reverse side of form - ACT SCORE _____

FOR MEDICAL STAFF:

BP _____ P _____ R _____ HT _____ WT _____ PF _____ TEMP _____