Allergy, Asthma & Immunology Center
Thomas J. Shen, MD

Welcome to the Allergy, Asthma & Immunology Center! We look forward to seeing you for your first appointment with:

Date: _____ Time: _____

☐ Dr. Thomas Shen, MD ☐ James Korray, ARNP

☐ **Leesburg Office**
8245 County Road 44 Leg-A, Ste 1
Leesburg, FL 34788
Phone: (352) 314-2929
Fax: (352) 314-9747

☐ **Villages Office**
910 Old Camp Road, Ste 152
The Villages, FL 32162
Phone: (352) 391-1437
Fax: (352) 391-1457

Please bring this paperwork, list of medications, insurance card(s), and photo ID to your appointment. **Plan on staying for two hours for your first appointment**. If you have any relevant medical records, please bring them to the front desk and we will make copies. You may also ask your other doctors to send paperwork via fax, see above for our fax numbers.

Every patient's first appointment involves a consultation. Depending on your specific situation, you and the provider may agree to perform allergy skin tests. We can do skin testing in office, but **you will need to stay off of the following medications 72 hours (three days)** before your appointment:

Antihistamines:

- azelastine (Astelin, Optivar)
- brompheniramine (Lodrane)
- carbinoxamine (Palgic)
- cetirizine (Zyrtec)
- chlorpheniramine (Chlor-Trimeton)
- clemastine (Tavist)
- desloratadine (Clarinex)
- dexbrompheniramine (Drixoral)
- diphenhydramine (Benadryl, Sominex, Unisom)
- fexofenadine (Allegra)
- hydroxyzine (Vistaril, Hyzine, Atarax)
- levocetirizine (Xyzal)
- loratadine (Claritin)
- pheniramine (Avil)
- phenyltoloxamine
- promethazine (Phenergan, Histantil)
- pyrilamine
- terfenadine
- triprolidine (Actidil, Zymine)

Tranquilizers:

- amitriptyline (Elavil)
- clorazepate (Tranxene)
- doxepin (Sinequan)
- meprobamate (Equanil)
- trifluoperazine (Stelazine)
- trazadone

Common Over-the-counter Medications:

- Alavert
- Alka Seltzer Plus
- Allegra
- Astelin
- Bayer Extra Strength Caplets
- Benadryl
- Chlor-Trimeton
- Claritin
- Comtrex
- Dimetane
- Drixoral
- Dymista
- Excedrin PM
- Midol Complete
- Midol PM
- NyQuil
- Nytol
- Robitussen
- Simply Sleep
- Sominex
- Tavist
- Theraflu
- Tylenol Cold + Flu Severe Night
- Tylenol Cold Max Nighttime
- Tylenol PM
- Unisom
- Zyrtec

The following medications are usually OK to take (**check the label** against the above lists):

- Antibiotics
- Antiepileptic drugs (anticonvulsant/antiseizure)
- Aspirin (except “Bayer Extra Strength Caplets”)
- Asthma Inhalers
- corticosteroids (eg: Flonase/fluticasone)
- klonopin (Clonazepam)
- lorazepan (Ativan)
- montelukast (Singulair)
- Mucinex
- Nasal Sprays (except Astelin)
- steroids
- theophylline
- zolpidem (Ambien)

If you have any questions about a particular medication or questions in general, please contact us at either (352) 314-2929 for the Leesburg office or (352) 391-1437 for the Villages office.

We understand that unexpected events may require you to cancel or reschedule your appointment. Please call to cancel 24 hours before your scheduled appointment, so that we can schedule other patients in that slot. If you are unable to contact us in advance of a cancellation, we may charge a $25.00 fee.

CONFIDENTIAL

Welcome to Allergy, Asthma & Immunology Center

Please have ALL paperwork completed at time of appointment

****Please do not wear any perfume, cologne or scented lotions****

Date _____ Date of Birth _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Phone# _____ SS# _____

Email address _____

Primary Care Doctor _____

Address _____

Phone# _____

Pharmacy Name _____

Pharmacy Phone _____

*****WE HAVE A $ 25.00 NO SHOW FEE, FOR APPOINTMENTS CANCELLED LESS THAN 24 HOURS PRIOR TO THE APPOINTMENT SCHEDULED. *****

INSURANCE COVERAGE WAIVER

WE FILE INSJURANCE FOR OUR PATIENTS AS A COURTESY. IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANIES FOR COVERAGE, TO CHECK PARTICIPATING PROVIDERS AND ANY OTHER QUESTIONS YOU MAY HAVE CONCERNING YOUR INSURANCE. IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES IN YOUR INSURANCE.

I WISH TO RECEIVE MEDICAL SERVICES AND I UNDERSTAND THAT IF FOR ANY REASON MY INSURANCE DOES NOT PAY FOR SERVICES RENDERED THAT I WILL BE RESPONSIBLE FOR PAYMENT TO ALLERGY, ASHTMA & IMMUNOLOGY CENTER

I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYS OR DEDUCTABLES AT THE TIME OF MY VISIT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR MAKING SURE THAT ANY REFFERAL OR AUTHOIZATION NEEDED FOR MY VISIT FROM MY PRIMARY CARE PHYSICIAN IS OBTAINED PRIOR TO MY VISIT.

I (OR MY GUARDIANOR PARENT) AUTHORIZE ALLERGY, ASTHMA & IMMUNOLOGY CENTER TO PROVIDE MEDICAL CARE REASONABLE TO TODAYS STANDARDS.

WE ARE REQUIRED TO PROVIDE YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH STATES HOW WE WILL NOT RELEASE ANY PRIVATE INFORMATION WITHOUT WRITTEN CONSENT FROM YOU THE PATIENT OR PATIENTS GUARDIAN OR PARENT.

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATES AND UNDERSTAND THEM.

_____

Please print your name here

_____

Signature

_____

Date

ALLERGY QUESTIONNAIRE

Instructions: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem.

Patients Name:

1. Briefly describe the reason for your visit today: _____

2. **PROBLEMS:** Have you ever had the following conditions? Please check yes or no.

Yes	No		Age at onset
		Asthma (Wheezing)	
		Any other breathing problems	
		Sinus Trouble	
		Hay fever (running, stuffy, itchy nose, sneezing)	
		Eczema or other rashes	
		Frequent infections	
		Reactions to foods	
		Drug reactions (please list if any reactions)	
		Insect bite reactions (please list if any reactions)	

3. **Symptons:** Have you ever had any of the following? If not leave blank?

	Circle the season symptons are most severe			
Runny or stuffy nose	Spring	Summer	Winter	Fall
Itchy nose	Spring	Summer	Winter	Fall
Sneezing	Spring	Summer	Winter	Fall
Itchy eyes	Spring	Summer	Winter	Fall
Wheezing	Spring	Summer	Winter	Fall
Coughing	Spring	Summer	Winter	Fall
Wheezing	Spring	Summer	Winter	Fall
Skin problems	Spring	Summer	Winter	Fall

4. **FOOD REACTIONS:** Have you ever had any reactions to foods that you have eaten? If so please explain: _____

_____

_____

5. **PRECIPITATING FACTORS/TRIGGERS:** Please check yes or no to the following precipitants/triggers as to whether or not they affect your symptoms.

	Yes	No		Yes	No
Cutting or playing in grass			Strong odors, Specify:		
High winds			Exposure to animals		
Other outdoor exposures			Colds or viruses		
Moldy/mildewed areas or items			Physical exertion or exercise		
Sweeping or dusting			Cold weather		
Tobacco smoke			Colognes or perfumes		
Air conditioning or heating					
Cleaning agents, Specify:					

6. **RESIDENCE:** List your past residences with the most recent first.

City and State	Number of years	Effect on symptoms(better, worse, no change)

7. **PREVIOUS ALLERGY EVALUATION AND THERAPY**

Have you ever had allergy skin tests?
If yes, when_____
Results of these tests:_____

_____

Have you ever received allergy injections?
If yes, when_____
Please list all medications that you have taken in the past for allergies.

_____

_____

Please list all other medications that you are now taking, including any vitamins.

_____

_____

_____

8. **OTHER MEDICAL PROBLEMS:** Have you ever had any of the following? **Answer all items.**

	YES	NO		YES	NO		YES	NO
Frequent headaches			Pneumonia			Diabetes		
Frequent nosebleeds			Cough up blood			Liver trouble		
Nasal Polyps			Tuberculosis			Frequent diarrhea		
Sinus operation			Chest x-ray			Sexual problems		
Sinus x-rays			Heart trouble			Bedwetting		
Ear infections			High blood pressure			Poison ivy or oak		
Hearing problems			Chest pain					
Glaucoma			Frequent heartburn					
Tonsils/Adenoids Removed			Kidney or bladder problems					

9. **HOSPITALIZATIONS AND SURGERIES:** Please list dates and reason.

10. **FAMILY ALLERGY AND MEDICAL HISTORY:**

	Yes	No	If yes, list all relatives (parents, siblings, children, aunts, uncles, etc)
Asthma			
Hay Fever			
Eczema			
Hives or swelling			
Frequent pneumonia			
Headaches			
Emphysema			
Cystic Fibrosis			
Tuberculosis			
Thyroid disease			
Glaucoma			
Diabetes			

Heart disease			
Lung disease			
Other conditions			

11. ENVIRONMENTAL SURVEY:

Where do you live? (city or rural)	House construction (brick, wood, etc.)
Age of home:	Do you have (a) an air cleaner? (b) an air humidifier?
Are any rooms damp or musty?	Type of air conditioning (central, window, etc)
Type of heating (forced air, steam, spaceheater, baseboard, electric, etc.)	Is there carpeting in the household?
What type of padding?	Do you have any: Stuffed furniture? Feather comforters?
How old is your: Pillow? Mattress?	Is your mattress: Foam rubber Cotton Innerspring & cotton Waterbed Encased in cotton Other
Is you pillow: Feather Foam rubber Dacron Other Encased in plastic	What kinds of grasses, shrubs and trees are in the immediate vicinity of your home?
Do you have pets? List number and kind (dog, cat, birds, horses, etc)	Do your pets spend time indoors?

What type of work do you do?

Are you exposed to anything at work that might aggravate your condition?
If so what:

Have you missed any time from work or school because of your allergies or asthma?
How much time?

Do you have any other exposures from hobbies, recreational activities, etc?

12. EVALUATION:

How would you describe yourself (or your child if he/she is being evaluated) Circle all that apply.

Timid	Concerned	Quite
Depressed	Aggressive	Bustling
Forward	Happy	Unfriendly
Anxious	Introvert	Many friends
Tense	Shy	Calm
Relaxed	Well adjusted	Independent
Few friends	Manipulative	Spoiled
Extrovert	Dependent	Usually ill

13. SMOKING/WEIGHT

Have you ever smoked?_____
If yes, for how many years?_____
Do you presently smoke?_____
When did you stop?_____
Average cigarettes per day_____
If you still smoke do you think you could stop?_____
Are there any other family members who smoke?____
If yes, which ones_____
_____
Weight now_____Weight one year ago_____
Maximum weight_____When_____