

Re-Test Questionnaire

C. Steven Smith, MD • Accredited Asthma & Allergy Care, PSC • 1017 Dupont Square North • Louisville, KY 40207
502-895-3330 • www.drsmithallergy.com

Name:	Date:	Age:	<input type="checkbox"/> M <input type="checkbox"/> F
Referring Physician:			

Do you have any unresolved or new symptoms? Please list.

YOUR CURRENT MEDICATIONS		
MEDICATION	STRENGTH	TIMES TAKEN PER DAY

Date of most recent influenza/pneumococcal vaccine: _____

LIST MEDICATION INTOLERANCES/ALLERGIES	
MEDICATION	INTOLERANCE/ALLERGIC REACTION

ENVIRONMENTAL EXPOSURE

Has there been any water leakage in your home? YES NO
 Rooms with carpeting: bedroom living room family room How old?
 Type of pillow or comforter: feather dacron foam How old?
 Are your pillow and mattress in a mite dust-proof encasement?
 Do you have any pets? cat dog bird Indoor or Outdoor?
 Exposed to other animals? _____
 Does anyone smoke in your home? YES NO
 Are you smoking cigarettes? YES NO
 Are you currently exposed to job related allergens or irritants? Y N
 Do you have allergic reactions to natural rubber latex gloves, balloons, condoms, etc.? YES NO

DIETARY HISTORY

Height: _____ Present weight: _____ Usual weight: _____
 Do you follow any special diet at home? YES NO
 If yes, explain: _____
 Do you avoid any major food groups such as milk products, meats, fruits, etc.? _____
 Do you have IBS, chronic colitis, or I.C.? _____
 Have you been diagnosed allergic/intolerant to foods? YES NO

REVIEW OF SYMPTOMS

Please circle any of the following symptoms which you are currently experiencing or that have caused you serious problems in the past:

General: fever weight loss weight gain night sweats fatigue severe itching loss of appetite
cold intolerance heat intolerance

Ear/Nose: loss of vision blurry vision cataracts glaucoma loss of hearing ringing in ears

Throat/Eye: loss of balance loss of sense of smell/taste excessive tearing dry eyes itchy eyes
conjunctivitis ear infections dry mouth postnasal drainage

Lymph glands: glandular swelling glandular tenderness

Heart: chest pain palpitations swelling in ankles inability to lie flat in bed

Lungs: shortness of breath wheezing recurrent infections

Intestinal tract: nausea vomiting heartburn indigestion abdominal pain diarrhea blood in stool
acid or sour taste in mouth excessive gas constipation gallstones food intolerances

Reproductive: irregular periods skipped periods unusual vaginal bleeding menopause infertility
miscarriages impotence pregnancy

Urinary: kidney stones inability to urinate prostate problems kidney infections

Rheumatologic: early morning joint stiffness joint swelling joint pain gout low back pain

Orthopedic: osteoporosis fractured bones

Skin: skin rash hives eczema skin tumors/growths excessive hair loss

Neurologic: fainting spells severe headaches epilepsy difficulty with memory inability to concentrate

Psychological: lack of energy anger depression other mental illness _____

PATIENT INFORMATION

(Please Print)

THIS SECTION IS PERTAINING TO THE PATIENT

NAME _____ SEX _____ BIRTHDATE ____/____/____ AGE ____
(Last) (First) (Middle)

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____ CELL PHONE () _____ - _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ EMPLOYER _____

MARITAL STATUS: M S W D IF MARRIED, NAME OF SPOUSE _____
(Circle One)

IF PATIENT IS A CHILD, NAME OF MOTHER AND FATHER _____ CHILD LIVES WITH: _____

PLEASE PROVIDE YOUR EMAIL ADDRESS: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

NAME _____ ADDRESS _____
(Street) (City) (State) (Zip)

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____ CELL PHONE () _____ - _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ EMPLOYER _____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ BIRTHDATE ____/____/____ SS# _____ - _____ - _____

ID NUMBER _____ GROUP NUMBER _____

EFFECTIVE DATE _____ RELATIONSHIP OF PATIENT TO SUBSCRIBER _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ BIRTHDATE ____/____/____ SS# _____ - _____ - _____

ID NUMBER _____ GROUP NUMBER _____

EFFECTIVE DATE _____ RELATIONSHIP OF PATIENT TO SUBSCRIBER _____

FAMILY PHYSICIAN AND REFERRAL INFORMATION

NAME OF FAMILY PHYSICIAN _____ PHONE () _____ - _____
(Required)

ADDRESS _____
(Street) (City) (State) (Zip)

NAME OF REFERRING PHYSICIAN _____ PHONE () _____ - _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Physician [who?], Friend/Family Member [who?], Phone Book, Internet, T.V., other, etc.)

IN CASE OF EMERGENCY, CONTACT: (Someone in another household, i.e. grandparent, friend, etc.)

NAME: _____ RELATIONSHIP: _____ PHONE () _____ - _____

AUTHORIZATION TO PAY INSURANCE BENEFITS & RELEASE INFORMATION TO INSURANCE COMPANY:

I hereby authorize payment directly to Accredited Asthma and Allergy Care, PSC. I understand that I am financially responsible for all co-pays, deductibles, and services not covered by my insurance. I authorize Accredited Asthma and Allergy Care, PSC to release information required to complete my insurance claim.

PATIENT OR GUARDIAN'S SIGNATURE: _____ **DATE:** ____/____/____

ANTIHISTAMINES

****STOP these medications
DAYS prior to testing**** 5-7

BRAND NAME	GENERIC NAME
Actifed Sinus Day	Diphenhydramine
Adapin	Doxepin
Ahist	
Aler-Dryl	Diphenhydramine
Alavert	
Allegra	Fexofenadine
Aller-Chlor	Chlorpheniramine
Allerhist-1	Clemastine
Astelin	Azelastine
Atarax	Hydroxyzine
Banophren	Diphenhydramine
Benadryl	Diphenhydramine
C.P.M.	Chlorpheniramine
Calm-Aid	Diphenhydramine
Chlo-Amine	Chlorpheniramine
Chlorphen	Chlorpheniramine
Chlorpromazine	Phenothiazines
Chlor-Trimeton	Chlorpheniramine
Clarinet	
Claritin	Loratadine
Compoz Nighttime Sleep Aid	Diphenhydramine
Contact 12 Hour Allergy	Clemastine
Diphedryl	Diphenhydramine
Diphen	Diphenhydramine
Effidac-24	Chlorpheniramine
Genahist	Diphenhydramine
Hydramine	Diphenhydramine
Nu-Med	Diphenhydramine
Nytol Caplet	Diphenhydramine
Optivar	Azelastine
PBZ & PBZ-SR	Tripelennamine
Periactin	Cyproheptadine
Phenegran	Promethazine
Promentazine	Promethazine
Prorex	Promethazine
Quintadrill	Mequitazine
Rezine	Hydroxyzine
Ridraman	Chlorpheniramine
Semprex-D	
Sinequan	Doxepin
Sominex	Diphenhydramine
Stahist	
Tagamet	Cimetidine
Tavist-1	Clemastine
Thorazine	Phenothiazines
Tofranil	Imipramines
Twilite	Diphenhydramine
Tylonol PM	Diphenhydramine
Unisom Sleepgels	Diphenhydramine
Vistanil	Hydroxyzine
Xyzal	
Zantac	Ranitidine
Zantac	Ketotifen
Zonalon	Doxepin
Zonalon	Ebastine
Zyrtec	Cetirizine

TRICYCLIC ANTIDEPRESSANTS

****These medications need to be stopped 7-10 days
prior to testing. Please contact the ordering
physician before stopping these medications.****
Please contact our office if you have any questions

BRAND NAME	GENERIC NAME
Adapin	Doexpin
Adapin	Doxepin
Ambivalon	Amitriptylinoxide
Amioxid	Amitriptylinoxide
Anafranil	Clomipramine
Asendin	Amoxampine
Aventyl Hydrochloride	Nortriptyline
Deparon	Demexiptiline
Elavil	Amitriptyline
Endep	Amitriptyline
Equilibrin	Amitriptylinoxide
Etrafon	Amitriptyline
Evadyne	Butriptyline
Istonil	Dimetacrine
Istonyl	Dimetacrine
Laroxyl	Amitriptyline
Limbitrol	Amitriptyline
Miroistonil	Dimetacrine
Norpramin	Desipramine
Noveril	Dibenzepin
Pamelor	Nortriptyline
Pertofrane	Desipramine
Prothiaden	Dosulepin
Sinequan	Doxepin
Surmontil	Trimipramine
Tinoran	Demexiptiline
Tofranil	Imipramine
Tryptizol	Amitriptyline
Vanatrip	Amitriptyline
Victoril	Dibenzepin
Vivactil	Protriptyline
Janimine	Imipramine
Praminil	Imipramine
Imiprex	Imipraminoxide
Elepsin	Imipraminoxide
Lomont	Lofepamine
Gamanil	Lofepamine
Deanxit	Melitracen
Dixeran	Melitracen
Melixeran	Melitracen
Trausabun	Melitracen
Timaxel	Metapramine
Sintamil	Nitroxazepine
Agedal	Noxiptiline
Elronon	Noxiptiline
Nogedal	Noxiptiline
Azafen	Pipofezine
Depressin	Propizepine
Vagran	Propizepine
Kevopril	Quinupramine
Kinupril	Quinupramine
Adeprim	Quinupramine
Quinuprine	Quinupramine

BETA BLOCKERS

****Do not take these medications the MORNING OF
your appointment****

BRAND NAME	GENERIC NAME
AK-Beta	Levobununolol
Betagan	Levobununolol
Betapace Tablets	Sotalol
Betimol	Timolol
Betoptic	Betaxolol
Biocarden	Timolol maleate
Brevibloc Injection	Esmolol
Cartol Filmstab Tablets	Carteolol
Coreg	Carvedilol
Corgard	Nadolol
Inderal Injectable and LA	Propranolol
Inderide LA	Propranolol
Isoptin SR	Verapamil
Kerlone	Betaxolol
Lopressor HCT	Metoprolol
Nadolol Tablets	Nadolol
Normodyne	Labetalol
Ocumer	Timolol
Ocupress	Carteolol
Normodyne	Labetalol
Sectral Capsules	Acebutolol
Sorine	Sotalol
Ocupress	Carteolol
Tenoretic 50 & 100	Atenolol
Tenormin I.V. Inj. & Tabs.	Atenolol
Sectral Capsules	Acebutolol
Sorine	Sotalol
Timolide Tablets	Timolol maleate
Toprol-XL	Metoprolol
Trandate	Labetalol