TANNER CLINIC
ALLERGY | ASTHMA | IMMUNOLOGY

Be aware that submission through electronic means may not be secure. Faxing is more secure than emailing.

Instructions: Please answer the following questions as completely and accurately as possible. The parent should fill out the form for patients under the age of 15.

NEW PATIENT QUESTIONNAIRE

Today's Date _____

Patient's Name _____ DOB _____ Sex: ☐M ☐F

How did you hear about our clinic or who were you referred by? _____

Reason for Allergy visit (briefly describe): _____

_____

A. Please check the conditions that have bothered you in the last 12 months:

Nose:
- ☐ Stuffy
- ☐ Sneezing
- ☐ Itching
- ☐ Draining
- ☐ Bleeding
- ☐ Mouth breathing
- ☐ Snoring
- ☐ Loss of smell
- ☐ Frequent sinus infections

Eyes:
- ☐ Itching
- ☐ Burning
- ☐ Watering
- ☐ Swelling

Throat:
- ☐ Itching
- ☐ Draining
- ☐ Throat clearing
- ☐ Soreness
- ☐ Hoarseness
- ☐ Loss of Taste

Ears:
- ☐ Itching
- ☐ Popping
- ☐ Draining
- ☐ Ringing
- ☐ Hearing Loss
- ☐ Fluid behind eardrums
- ☐ Frequent ear infections

Respiratory:
- ☐ Cough
- ☐ Wheeze
- ☐ Shortness of Breath
- ☐ Tightness
- ☐ Phlegm (mucus)
- ☐ Bronchitis
- ☐ Pneumonia

Gastrointestinal
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Poor appetite
- ☐ Poor weight gain
- ☐ Heartburn/acid reflux

Nervous System:
- ☐ Headache
- ☐ Unusual tiredness
- ☐ Irritability

Skin:
- ☐ Hives
- ☐ Itch
- ☐ Swelling

Musculoskeletal:
- ☐ Muscle pains
- ☐ Joint pains

Cardiovascular:
- ☐ Heart racing
- ☐ Chest pain

Constitutional:
- ☐ Fevers

Allergy:
- ☐ Food allergy

Endocrine:
- ☐ Heat/cold intolerance

Other symptoms not listed above: _____

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History of Present Illness:

	Nose/Eye	Chest	Skin
When did these symptoms begin (year)?			_____
Where did these symptoms begin (state)?	_____		_____
When did these symptoms occur last (date)?	_____		
What time of day are these symptoms worse?	_____		_____

Check off the month(s) your symptoms occur.

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☑ Dec

B. What medications or treatments have you taken in the past for your allergies and/or asthma?

		Helpful? Yes	Helpful? No			Helpful? Yes	Helpful? No
1.		☐	☐	5.	_____	☐	☐
2.		☐	☐	6.	_____	☐	☐
3.		☐	☐	7.	_____	☐	☐
4.	_____	☐	☐	8.	_____	☐	☐

C. Please list all your current medications and reasons for taking them:

_____
_____
_____
_____
_____
_____
_____
_____
_____

D. Have you ever been on allergy shots (immunotherapy)? If yes, when, for how long, and to what?

_____
_____

Past Medical History

E. Please list any medication allergies including a description of any reactions:

_____

F. Please list any past or current medical problems not yet mentioned above, including any surgeries:

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G. Please list any medical problems that run in your immediate family:

Relationship (mother, brother, daughter, etc.)

Asthma: _____
Hay Fever or Allergic Rhinitis: _____
Eczema: _____
Immunodeficiency of any type: _____

Any other medical problems in the family:

_____ _____
_____ _____
_____

H. Personal History:

Do you smoke? _____ How many packs per day? _____ How Long have you smoked? _____

Does anyone smoke at home or work? _____

Do you have any pets? If yes, type (cat, dog, etc.) and number.

_____

What is your occupation? _____

What is your exercise routine? _____

If the patient is a young child, does he/she attend daycare? _____

Signature _____ Date _____

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Patient Medical History Form

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Please fill out every space. If it does not pertain to you, please write N/A for "Not Applicable"

Patient Information

Last Name	First Name	M. Initial	DOB	Gender ☐ M ☐ F
Mailing Address		City	State	Zip
Home Phone #	Cell Phone #	Work Phone #	Social Security #	
Employer Name and Address			Email Address	
Marital Status	Spouse's Name	Spouse's DOB	Spouses Phone #	

Race ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Ethnicity - *Race/Ethnicity Questions are asked in order to identify additional care needs of our diverse patients. No discrimination intended*
☐ Caucasian ☐ Hispanic ☐ African American ☐ Pacific Islander ☐ American Indian/Alaska Native ☐ Asian

How did you hear about our Practice?
☐ Facebook ☐ Good 4 Utah ☐ Health Fair ☐ Insurance ☐ Internet Search ☐ KUTV ☐ Ogden Marathon ☐ Radio ☐ Seminar ☐ Twitter ☐ KSL
☐ Another Patient (Name): ☐ Other:
☐ Referring Provider: Provider Name Provider Ph # Facility

Responsible Party

☐ Self ☐ Mother ☐ Father ☐ Other:	Last Name (If not Patient)	First Name	DOB	Gender ☐ M ☐ F
Address		City	State	Zip
Primary Phone #	Social Security #	Employer	Business Phone #	

Parent/Guardian Information (Fill out if patient is under 18 yrs of age)

☐ Mother ☐ Father ☐ Other:	First & Last Name	Phone Number
☐ Mother ☐ Father ☐ Other:	First & Last Name	Phone Number

Insurance Information

Primary Insurance: Name & Address		ID #	Group #
Policy Holder Name	Policy Holder DOB	Social Security #	Effective Date
Policy Holder Address		Policy Holder Phone #	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other:
Secondary Insurance: Name & Address		ID #	Group #
Policy Holder Name	Policy Holder DOB	Social Security #	Effective Date
Policy Holder Address		Policy Holder Phone #	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other:

Emergency Contact

First & Last Name	Phone #	Relationship to Patient

If this visit is due to an accident, please provide the information here: ☐ Auto ☐ Industrial

Details:

Consent to Treat and to Disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above-named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclose of protected health information for treatment, payment, and health care operations. Patients injured at work typically obtain information through their adjuster or employer. I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy notice, my consent to treatment, and the above-listed uses of protected health information.

Signature of Patient/Responsible Party _____ Date _____

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No Show/Cancellation Policy

When your appointment with our office is scheduled, we make sure there is enough time & staff scheduled to provide you the necessary care for your visit. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This allows us to schedule other patients who may be waiting for an appointment.

- Arriving at our office any later than 10 minutes past your scheduled appointment is considered late and you will be asked to reschedule.
- Any new patient who fails to show up for their initial appointment with no communication, will not be rescheduled
- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and be charged a $50 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24-hour notice a **second time** will be charged a $100 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24-hour notice a **third time** will be dismissed from our office.
- The fee will be charged to the patient, not the insurance company, and is due at the time of the patient's next scheduled visit.

As a courtesy, reminder calls/texts are made for appointments. If you do not receive a reminder call or message, the above policy will still remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office. If there is no answer, leaving a message is acceptable.

I have read and understand the No Show/Cancellation Policy and agree to its terms.

Signature (Parent/Legal Guardian) **Relationship to patient**

Printed Name **Date**

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OUTSIDE FACILITY FORMS/LETTERS POLICY

Any and all outside facility required forms (School Medication Administration, FMLA, DMV, Functional Ability) are to be associated with an office visit and brought to an office visit in order to be completed at no extra charge.

For forms that are brought outside of a scheduled visit, the fees for completion of the forms are as follows:

- FMLA and any related disability forms - $300 per hour (time includes rough draft and finalization).
- School Medication Administration forms - $45 flat fee if not brought to a follow-up appointment in clinic.
- Any other outside facility forms with no appointment - $45 flat fee to complete.

Please be aware that it may take one week, 7 full days, to complete the form(s). Each form must be completed by the patient, to the extent possible, prior to providing form(s) to our clinic. An accurate return fax number or mailing address IS REQUIRED.

If these guidelines are not followed, the form will not be completed.

Thank you for your understanding.

Patient Name (printed) Date of Birth

Patient Signature of Agreement (if older than 18) Date

Parent/Guardian Name (printed) Relationship

Parent/Guardian Signature of Agreement Date

TANNER CLINIC
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POLICY NAME: Photographing, Video Recording, Audio Recording, and Other Imaging of Patients, Visitors, and Workforce Members

DATE: October 9, 2018

To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated thereunder, Rocky Mountain Allergy, Asthma, and Immunology at Tanner Clinic must take reasonable steps to protect patients, visitors, and workforce members from unauthorized photography, video or audio recordings, or other images due to the sensitive nature of patient information and to protect patient privacy.

Photographing/Audio Recording of Patients and Workforce Members by Patients, Family Members, and/or by the Patient's Visitors: The facility is not required to obtain consent from the patient when the patient is the subject of the photography/audio recording and such recording is performed by the patient or the patient's family members or the patient's visitors.
Patients, family members, and/or visitors are not permitted to take photographs of, or audio record, or video other patients or workforce members without written consent

I am signing the policy as my voluntary act and deed having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs, and assigns.

Patient Name Date of Birth

Name of Legal Representative (if different than above) Relationship to Patient

Signature of Individual or Legal Representative Date

Medications Check List

There are numerous medications, including some anti-depressant medications, that interfere with testing and should not be stopped due to the nature of the drugs. Please check with your physician or pharmacist if you have any questions about specific drugs not listed below. If you cannot comfortably or safely hold your medication, please discuss this with your physician.

The following medications (over the counter and prescription) MUST be discontinued for at least 5-7 days prior to any skin testing.

Be aware, most **oral allergy medications** and some **allergy nasal sprays** and **eye drops** contain antihistamines. Many **cough and cold medications** contain antihistamines. Some **sleep aids**, as well as **antacids**, contain or have antihistamine effects. Pay attention to off-brands as well. This list is not all-inclusive. Please contact our office if you have any questions.

Actifed
AccuHist
Antivert (meclizine)
Allegra (fexofenadine)
Allegra D
Aller-chlor (chlorpheniramine)
Alavert
Astelin Nasal Spray (azelastine)
Astepro Nasal Spray (azelastine)
Atarax (Hydroxazine)
Astrepro
Atrohist
Arbinoxa (carbinoxamine)
Benedryl (diphenhydramein) (2-3 days)
Bepreve eye drops
Bonine (meclizine)
Brompheniramine generic
Bromfed
carbinoxamine generic
Claritin or Clarinex (loratidine or desloratidine)
Claritin D
clemastine generic
Chlortrimeton (chlorpheniramine)
Cyproheptadine generic
Dimetapp
dexchlorpheniramine generic
dimenhydrinate generic, diphenhydramine generic, or doxylamine generic
Dramamine (dimenhydrinate), or Dramamine Less Drowsy (meclizine)
Dymista
Elestat eye drops (epinastine)
Emadine eye drops (emedastine)
Hydroxyzine generic
Lastacaft eye drops (alcaftadine ophthalmic)
Marezine (cyclizine)
Meclizine
Opcon-A eye drops (napazoline)
Optivar eye drops (azelastine)
Pataday
Patanase
Patanol/Pataday
Palgic (carbinoxamine)
Periactin (cyproheptadine)
Phenergan (promethazine)
promethazine generic
Rhinotan
Semprex D
Tavist Allergy (clemastine)
Triaminic
Tripohist triprolidine
Unisom (diphenhydramine)
Vistaril (hydroxyzine)
Xyzal (levocetirizine)
Zyrtec (cetirizine)
Zyrtec D
Zaditor eye drops (ketotifen)
Zentrip (meclizine)

Also, please avoid the following **antacids** which have antihistamine effects for one week.

Axid (nizatidine)
cimetidine generic
Duexis (ibuprofen/famotidine)
famotidine generic
nizatidine generic
Pepcid (famotidine)
Pepcid AC (famotidine)
Pepcid AC Maximum Strength (famotidine)
Ranitidine generic
Tagamet HB 200 (cimetidine)
Zantac (ranitidine)

The following medications do **NOT** interfere with testing and **MAY** be taken.

Advair
Albuterol
Antibiotics
Atrovent (Ipratropium)
Azmacort
Beclovent
Cromolyn
Dexilant
Dulera
Flonase
Flovent
Guaifed
Humibid
Midrin
Nasalcrom
Nasocort
Nasonex
Nexium (Esomeprazole)
Prednisone
Prednisolone (Prelone)
Prevacid (Lansoprazole)
Prilosec (Omeprazole)
Proair
Protonix (Pantoprazole)
Proventil
Pulmicort (Budesonide)
QNasl
QVar
Rhonicort
Serevent
Singulair (Montelukast)
Slobid
Spiriva (Tioptropium)
Sudafed (Pseudephedrine)
Tilade
Vancenase
Vanceril
Ventolin
Veramyst
Zetonna

***** On some occasions, even if you have avoided the above medications, the physician may decide that a blood test would be indicated before allergy testing is performed *****