JOHNSON MEDICAL ASSOCIATES
Comprehensive Medicine | Traditional | Holistic | Alternative

DEAR PATIENT,

I would like to personally thank you for your interest in Johnson Medical Associates and I'm looking forward to helping meet your medical needs. Enclosed in this packet are the following:

- PATIENT REGISTRATION FORM
- PATIENT HISTORY FORM
- NOTICE AND RECEIPT OF PRIVACY PRACTICES
- PATIENT CONFIDENTIALITY DIRECTIVE
- MEDICAL RELEASE FORM (FOR OPTIONAL USE)

Please allow sufficient time to fill out the enclosed forms and please **BRING THEM WITH YOU** to your appointment. This will make for a more complete, comprehensive medical assessment and diagnosis, as well as help our staff take care of you as efficiently as possible.

Because of the fact that many of our patients are highly sensitive to various environmental factors, we strive to create surroundings suitable for all patient requirements. Your adherence to the policies listed below as well as any sacrifices necessary on your part will be greatly appreciated by all. **LISTED BELOW ARE A FEW CLINIC POLICIES APPLICABLE TO ALL WHO ENTER THE CENTER.** Some may require changes in your normal routine on the day of your appointment, and while you are in the clinic:

- **PLEASE REFRAIN FROM THE USE OF THE FOLLOWING SCENTED PERSONAL CARE PRODUCTS**:
  - ✓HAND SOAP WITH PERFUME
  - ✓SCENTED LAUNDRY DETERGENT
  - ✓FABRIC SOFTENER
  - ✓PERFUME
  - ✓SCENTED AFTERSHAVE
  - ✓SCENTED HAIR SPRAY
  - ✓SHAMPOO WITH FRAGRANCE
  - ✓CONDITIONER WITH FRAGRANCE
  - ✓SCENTED DEODORANT
  - ✓PERFUMED BATH POWDERS
  - ✓HAND LOTION WITH FRAGRANCE
  - ✓SCENTED COSMETICS

- **PLEASE REFRAIN FROM SMOKING AND EXPOSURE TO TOBACCO SMOKE** for at least **ONE TO TWO HOURS** before you arrive, as smoke clings to you, your clothes and hair. If you or anyone accompanying you to your appointment cannot "go without" tobacco that long, nicotine gum or a patch might help.

- **IF YOU ARE AN ALLERGY PATIENT** and have already been scheduled, or even anticipate that you will have a skin or challenge testing appointment, please:
  - ✓ AVOID TAKING ANTIHISTAMINES FOR 72 HOURS PRIOR TO THE APPOINTMENT
  - ✓ WEAR SHORT-SLEEVED GARMENTS TO YOUR SKIN-TESTING APPOINTMENT

APPOINTMENTS:

PATIENTS ARE SEEN BY APPOINTMENT ONLY. If you become ill and need to be seen right away, please call our office to arrange an appointment as soon as possible. Our office hours are:

- Monday—Thursday: 8:30 A.M.—5:00 P.M.
- Friday: 8:30 A.M.—12:30 P.M.

997 Hampshire Lane Richardson Texas 75080
www.johnsonmedicalassociates.com
972 479 0400 | 972 479 9435 fax | 800 807 7555

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PLEASE CALL OUR MAIN OFFICE NUMBER FOR AN APPOINTMENT OR AN AFTER-HOURS EMERGENCY:

- ✓972-479-0400
- ✓1-800-807-7555 (Toll-free)

FOLLOW THE PROMPTS ON THE AUTOMATED MESSAGE TO MAKE AN APPOINTMENT OR TO HAVE YOUR PHYSICIAN PAGED IN CASE OF AN EMERGENCY.

FINANCIAL POLICIES:

Payment is expected at the time of service. We accept checks, cash, Care Credit, VISA, MasterCard, Discover and American Express credit cards. We will provide you a Super bill for you to file with your insurance provider.

MEDICARE PATIENTS:

All physicians are required by law to file Medicare forms for all Medicare patients. JMA is categorized as a non-participating Medicare provider, and patients are charged the limiting charge for covered services at the time of their office visit. Non-covered services are charged at our standard office rates and payable at the time of service. We do not accept Medicaid as we are not a Medicaid provider.

Thank you again for choosing JOHNSON MEDICAL ASSOCIATES for your health needs. My staff and I will personally do all that we can to make your visit a positive and productive experience.

Sincerely,

Alfred R. Johnson, D.O.
Medical Director
Johnson Medical Associates

997 Hampshire Lane Richardson Texas 75080
www.johnsonmedicalassociates.com
972 479 0400 | 972 479 9435 fax | 800 807 7555

JOHNSON MEDICAL ASSOCIATES

PATIENT REGISTRATION

Patient Name: _____ Birth Date: _____/_____/_____
Last First Middle

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____-_____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Fax: _____-_____-_____

Cell Phone: _____-_____-_____ E-mail: _____

Social Security No.: _____/_____/_____ Driver's License No.: _____State: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other ☐ Sex: M ☐ F ☐

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Referred by: _____ Dr. ☐ Friend ☐ Other ☐ _____ Phone: _____-_____-_____

Primary Care Physician: _____ Phone: _____-_____-_____

RESPONSIBLE PARTY/PRIMARY INSURED /Parent or Guardian (IF NOT PATIENT)

Name: _____, _____ Relationship: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____ _____ Phone: _____-_____-_____

Insurance Co.: _____ Policy No.: _____Phone: _____-_____-_____

Address: _____City: _____State: _____ Zip Code: _____-_____

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT FOR TREATMENT

I consent to care and treatment by **Johnson Medical Associates, P.A.** as may be prescribed by same and/or dictated by professional standards. The nature, purpose, benefits, and risks of all care and service have been explained to me. I authorize the release of patient health information (PHI) in order to carry out the treatment, payment of healthcare operation (TPO) to the practice of **Johnson Medical Associates, P.A.** Treatment includes the provision, coordination or management of healthcare and related services by one or more healthcare providers, or the referral of a patient for healthcare from one provider to another. Payment means the activities conducted by the practice to obtain reimbursement for healthcare services. This includes, among others, billing, claims management, collection activities, verification of insurance coverage, and pre-certification of services. If I am a person different from the patient, this authorization is on the patient's behalf and is permission to use a copy of this authorization in place of the original.

Insurance Filing: Some of the procedures we provide are not covered by most insurance companies, and may be deemed as "not medically necessary" and non-reimbursable. We will provide medical records at the request of your insurance company after their receipt of the insurance claim form you submitted. Our office is unable to provide any additional assistance in obtaining reimbursement for services provided.

FINANCIAL AND MEDICARE POLICIES

PAYMENT IS EXPECTED AT TIME OF SERVICE. We will provide you with the necessary forms to file with your insurance provider. We accept **VISA, MasterCard, American Express, and Discover.**

MEDICARE POLICY: If **Johnson Medical Associates, P.A.** determines that the services provided do not meet the requirements for coverage under Medicare; I verify that I received a MEDICARE WAIVER informing me of this possibility. As a non-participating Medicare provider, patients are charged the limiting charge for covered services at the time rendered. Non-covered services will be charged at our standard office rates.

_____ _____/_____/_____
Patient or Guardian Signature Date

Tel: 972-479-0400 ●997 Hampshire Lane ● Richardson, Texas 75080 ● Fax: 972-479-9435

JOHNSON MEDICAL ASSOCIATES

PATIENT CONFIDENTIALITY DIRECTIVE

_____ _____

Patient name (Please print) **Date**

1. Please list the family members or other persons, *if any*, whom we may inform about your diagnosis. This also includes information about treatment, payment, and health care operations.

   _____
   _____
   _____

2. Please list the family members or significant others, *if any*, who we may inform about your medical condition, but **ONLY DURING AN EMERGENCY SITUATION:**

   _____
   _____
   _____

3. Please print the address of where you would like postcards and/or any other personal correspondence from our office to be sent, *if other than your home address*.

   _____
   _____
   _____

4. Please indicate *if you want* all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   ☐ Yes ☐ No

5. Please print the telephone number, *if any*, where you want to receive calls about your appointments, lab and x-ray results or other health care information *if other* than your home phone number: (_____) _____ or (_____) _____

   **I am fully aware that a cell phone is not a secure and private line*.

6. Can confidential messages, such as appointment confirmation, lab or test results be left on your home answering machine or voicemail?

   ☐ Yes ☐ No

_____ _____

Patient or Guardian signature (if patient is under 18 years) Date signed

NOTE: You, as the patient, have the right to change this directive at any time by filling out and signing a new form.

JOHNSON MEDICAL ASSOCIATES

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

DATE: _____/_____20_____

PATIENT'S PRINTED NAME: _____

I have received a copy of **JOHNSON MEDICAL ASSOCIATES'** Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that the practice reserves the right to change the items of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

_____
Signature of Patient or Representative

DATE: _____/_____20_____

_____
Relationship to patient (if signed by a personal representative of patient.)

TEL: 972-479-0400 – 997 HAMPSHIRE LANE, RICHARDSON, TEXAS 75080 FAX: 972-479-9435

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AFFIDAVIT FOR MEDICAL SERVCIES PROVIDED BY JOHNSON MEDICAL ASSOCIATES, P.A. OR HYPERBARIC CENTERS OF TEXAS.

I, the undersigned, do hereby consent and agree that Johnson Medical Associates, Hyperbaric Centers of Texas, their employees, or agents have the right to bill me for the professional medical services at the fee that is quoted.

I also understand that Medicare, Tri-Care or any other health insurance may not pay for these services and that I am responsible for the expense or liability incurred.

Name: _____ Date: _____

Address: _____

Phone: _____

Witness for the undersigned: _____

Signature: _____

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JOHNSON MEDICAL ASSOCIATES

PATIENT HEALTH HISTORY

This form will become part of your medical record and the contents will remain **CONFIDENTIAL.**
Please put a ☑ or an **X** in the **checkbox.** **PRINT** answers legibly. **Fill in the information as completely as possible**.
This form is part of your basic chart; to help your physician to determine and evaluate the cause of your illness and symptoms.
Your expenditure of time for accurate completion of this form is appreciated. **Pages 8-9 are optional if you have no allergies.**

Patient: _____
Last First Middle Nickname Birth date

Occupation? _____ of: ☐ Patient ☐ Father ☐ Mother

Referred By: _____ Regular physician: _____

Highest Education Level Completed: ☐ Grade School ☐ High School ☐ Tech School ☐ College ☐ Graduate Degree

Main reasons you're here: _____

List your symptoms and problems concisely, with rating of 1 to 5, 1 the least bothersome, and 5 the most bothersome.

What bothers you the most? _____

Do symptoms recur at regular intervals? _____ If so, please explain: _____

Date you or others first recognized symptoms/problems: _____ Other comments: _____

TREATMENT GOALS:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Please list generic and/or brand name, mg., mcg., I.U., pwd., liq. cap., tab., and current dose you take.

MEDICATIONS:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____

VITAMIN, MINERAL & NUTRITIONAL SUPPLEMENTS:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____

Date Form Completed: _____ Filled out by: _____ Relationship: _____

997 Hampshire Lane
Richardson, TX 75080

Tel: 972-479-0400
Fax: 972-479-9435

DIET, APPETITE, and FOOD REACTIONS

Current Diet: ☐ Rotation ☐ Vegetarian ☐ Atkins' ☐ Low Carb ☐ Low Fat ☐ Diabetic ☐ Hypoglycemic ☐ Vegan

☐ Zone ☐ Blood Type ☐ South Beach ☐ Weight Loss ☐ Low Salt ☐ Ayurveda ☐ Macrobiotic ☐ Other:

Appetite: ☐ Good ☐ Increased ☐ Poor ☐ Picky ☐ Changes ☐ Bulimia ☐ Anorexia

Eat excessively, after a meal or snack? ☐ Yes ☐ No ☐ Unexplained weight loss ☐ Unexplained weight gain

Do you gain weight easily? ☐ Yes ☐ No Exercise often? ☐ Yes ☐ No SPECIFY TYPE:

Foods crave, daily or more: ☐ Vegetables ☐ Carbs/bread ☐ Pastries ☐ Meat ☐ Sweet ☐ Dairy ☐ Fruit ☐ Fish Other:

Food(s) would miss the most if forbidden?

List any foods you avoid:

Explain why you avoid them:

Certain foods cause: ☐ Canker sores ☐ Hives ☐ Rash ☐ Itching ☐ Mouth ulcer ☐ Post-nasal drip Other:

☐ Feel worse after eating ☐ After 5 mins. ☐ In 1 hr. ☐ In 1-4 hrs. ☐ Tired after 8 hrs. sleep

Wake at: ☐ 1 AM ☐ 2 AM ☐ 3 AM ☐ 4 AM ☐ 5 AM ☐ Hungry or ☐ Thirsty FOR:

Record AM (basal) temperature in bed:_____ ☐ Fahrenheit ☐ Celsius ☐ Oral ☐ Axillary or ☐ Rectal

Alcohol use: ☐ Whiskey ☐ Vodka/Gin ☐ Tequila ☐ Wine ☐ Beer ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Rare

☐ Weekends ☐ Alcoholic Any symptoms from alcohol? ☐ Irritable/angry ☐ Depressed ☐ Sleepy ☐ Red face ☐ Dizzy ☐ Quiet

Thirst: ☐ Normal ☐ Increased ☐ No thirst ☐ Extreme ☐ 1-3 oz. ☐ 8-16 oz. ☐ Water ☐ Tea ☐ Coffee ☐ Cola

Ever had allergy testing? ☐ Yes ☐ No ☐ Skin pricks ☐ Scratch ☐ Intradermal ☐ Elisa ☐ RAST ☐ Sublingual

Tested for: ☐ Foods ☐ Air Pollen ☐ Chemicals ☐ Mold ☐ Fungi ☐ Cat hair ☐ Dog hair Other:

When? ☐ 1-2 yrs ago ☐ 3-5 yrs ago ☐ 6^{+} yrs ago Dr's name(s): Please attach test copy, if available.

Dietary allergy treatment: ☐ Rotation ☐ Elimination Other:

Allergy shots: ☐ Past ☐ Now ☐ Weekly ☐ 1-3 per wk ☐ Bi-weekly ☐ Monthly ☐ Winter ☐ Spring ☐ Summer ☐ Fall

How long on allergy shots? ☐ 1-2 yrs ☐ 3-5 yrs ☐ Oral Last dose on? Arm reaction? ☐ Yes ☐ No

☐ Improvement on shots ☐ No change

Comments:

GASTROINTESTINAL

Stomach: ☐ Aches ☐ Cramps ☐ Burp ☐ Bloated ☐ Hiccough ☐ Nausea ☐ Retching ☐ Vomiting ☐ Acid reflux

☐ H. pylori ☐ Ulcer ☐ Hiatal hernia ☐ Endoscopy ☐ Upper GI ☐ Bad Breath ☐ Surgery: Describe

☐ Burp & re-state food Which foods?

Abdomen: ☐ Gassy ☐ Full ☐ Fat ☐ Gas pain ☐ Swollen ☐ Flabby ☐ Pain/cramps ☐ Lower GI ☐ Irritable bowel

Hernia surgery? ☐ Inguinal ☐ Abdominal Colon surgery? ☐ Colostomy ☐ Ileostomy ☐ Tumors Other:

Rectal: ☐ Gas odor ☐ Anal fissure ☐ Itching ☐ Burning ☐ Hemorrhoidectomy_____ ☐ Hemorrhoids ☐ Prolapse

Colon/Intest: ☐ Polyps ☐ Colitis ☐ Duodenal Ulcer ☐ Diverticulitis ☐ Celiac disease ☐ Constipation ☐ Diarrhea

Stool: ☐ Foul odor ☐ Brown ☐ Green ☐ Yellow ☐ Narrow ☐ Large ☐ Dry ☐ Hard

Liver: ☐ Gall bladder surgery ☐ Gallstones ☐ Positive Epstein Barr ☐ Mononucleosis ☐ Hepatitis ☐ Cirrhosis ☐ Jaundice

Comments:

INFECTIOUS DISEASES and VENOMS etc.

☐ AIDS ☐ Hemophilus Influenza ☐ Staph infection ☐ Strep infection ☐ Coxsackie virus ☐ Chlamydia

☐ E. Coli ☐ Genital warts ☐ Gonorrhea ☐ Syphilis STD treated w/antibiotics? ☐ Yes ☐ No

☐ Encephalitis ☐ Malaria ☐ Meningitis ☐ Rheumatic fever ☐ Scarlet fever ☐ Polio ☐ Typhoid ☐ Yellow Fever ☐ Influenza

Measles: ☐ Rubeola (7-10 day) ☐ Rubella (German/3-day) ☐ Diphtheria ☐ Chicken pox ☐ Mumps ☐ Pertussis (whooping cough)

☐ Small pox ☐ Tetanus ☐ Typhus ☐ Tropical disease; specify: Bite: ☐ Dog ☐ Spider ☐ Snake Other:_____

☐ Rabies ☐ Lyme Disease ☐ Salmonella poisoning ☐ Botulism ☐ Bo Tox injections Other: _____

Medications:

Comments:

SKIN, CANDIDA and RELATED SYMPTOMS

☐ Many antibiotics in the past When?_____ ☐ Side effects: ☐ Hives ☐ Rash ☐ Diarrhea ☐ Stomach pain

Resulted in? ☐ Nausea ☐ Anaphylactic shock ☐ Vaginal yeast infection ☐ Prostate infection ☐ Rash/itching ☐ Thrush

Have itchy: ☐ Nose tip ☐ Roof of mouth ☐ Rectum ☐ Scalp ☐ Between shoulder blades ☐ Nostrils ☐ Ear canals

Itching: ☐ Bend of elbows or knees ☐ Rash in bend of elbows or knees Other: _____

Fungal infection: ☐ Toenails ☐ Fingernails ☐ Ringworm ☐ Pityriasis ☐ Athlete's foot

Nails are: ☐ Split/crack ☐ Thick ☐ Thin ☐ Brittle ☐ Other: Ridged: ☐ Across ☐ Vertical

Fingertips: ☐ Hang nails ☐ Warts ☐ Cracked ☐ Bleeding ☐ Eczema ☐ Callous Arthritic: ☐ Joints ☐ Nodes

Foot health: ☐ Bunions ☐ Plantar wart ☐ Cracked ☐ Bleeding ☐ Eczema ☐ Callous ☐ Corns Other:

Skin disease: ☐ Eczema ☐ Poison ivy ☐ Psoriasis ☐ Dandruff ☐ Sores ☐ Vitiligo ☐ Oily skin ☐ Oily hair

☐ Boils ☐ Rashes ☐ Impetigo ☐ Acne ☐ Flushed ☐ Pallor (white) ☐ Dry skin ☐ Excess or bad body odor

Herpes: ☐ Mouth ☐ Lips or face ☐ Shingles (herpes zoster) ☐ Skin surgery ☐ Face ☐ Upper limbs ☐ Lower limbs

When? Where? ☐ Skin cancer: Explain

Comments:

OVERALL HEALTH HISTORY

Please check **any** of the following that **you have had**. Please **indicate yea**r or **age,** even if it is close, rather than exact.

☐ Anemic ☐ Autistic ☐ Birth defect ☐ Blood disorder ☐ Cancer/malignant tumor Explain: ☐ Cerebral Palsy

Work stress: ☐ Mild ☐ Moderate ☐ Severe School stress: ☐ Mild ☐ Moderate ☐ Severe

Home stress: ☐ Mild ☐ Moderate ☐ Severe ☐ Nervous breakdown When/why:

☐ Blood transfusion for: ☐ Surgery ☐ Other:_____ # Pints:_____ Blood Type __ ☐ + ☐ —

Comments:

HEART, VASCULAR and CIRCULATION

Pulse: ☐ Rapid ☐ Irregular ☐ Slow ☐ Murmur ☐ Chest pain ☐ Congestive heart ☐ Pacemaker

☐ Rheumatic Heart ☐ Heart attack ☐ On Digitalis Other heart meds? Other:

☐ Palpitations Worse if: ☐ Walk ☐ Run ☐ Sit up fast ☐ Stand LYING ON: ☐ Left side ☐ Back ☐ Right side

Sensitive: ☐ Cold air ☐ Draft of air ☐ Fan ☐ Wear more clothes than most? Bruise: ☐ Easily ☐ No cause

☐ Cold feet ☐ Cold hands ☐ Cold Nose SWELLING OF: ☐ Face ☐ Legs ☐ Hands ☐ Ankles ☐ Abdomen

☐ Phlebitis ☐ Cold ☐ Hot PERSPIRE: ☐ Much ☐ Little LYMPH GLANDS: ☐ Sore ☐ Swollen ☐ Hard

Blood pressure: ☐ High ☐ Low ☐ Stroke(s) ☐ TIA(s) When? Effects:

Comments:

HEADACHE and RELATED SYMPTOMS

☐ Regular ☐ Severe ☐ Migraines ☐ Sinus ☐ Forehead ☐ Temples ☐ Eyes ☐ Top ☐ Back ☐ Sides ☐ Face

☐ Constant ☐ Throb ☐ Can't sleep ☐ OTC meds help Started age:____LAST:____ ☐ Hours ☐ Days ☐ Weeks

☐ Dizzy ☐ Nausea ☐ Vomiting ☐ Sleepy ☐ Weakness ☐ Go to Work HORMONAL: ☐ Menstrual ☐ Menopausal

Worse from: ☐ Food ☐ Tobacco ☐ Odors ☐ Cold drinks ☐ Cold food ☐ Beer ☐ Wine ☐ Liquor

Worse during: ☐ Spring ☐ Summer ☐ Autumn ☐ Winter ☐ Morning ☐ Daytime ☐ Evening ☐ Night

☐ Injury ☐ Concussion ☐ Brain scan ☐ MRI ☐ EEG ☐ X-rays ☐ Surgery Explain:

Comments:

CENTRAL NERVOUS SYSTEM and MEMORY

☐ Anxiety ☐ Confused ☐ Depressed ☐ Dizzy ☐ Feel Faint ☐ FATIGUE: ☐ On rising ☐ After meals ☐ Constant

☐ Feelings of rage ☐ Forgetful ☐ Hallucinate ☐ Hyperactive ☐ Indifferent ☐ Insomnia ☐ Irritable ☐ Listless

☐ Dr Jekyll/Hyde personality ☐ Mood swings ☐ Restless ☐ Seizures: ☐ Grand Mal ☐ Petit Mal ☐ Nightmares

☐ Poor concentration ☐ Sensitive to: ☐ Light ☐ Noise ☐ Odors ☐ Spacey ☐ Panic state or disorder

☐ Numbness ☐ Tingling ☐ ADD/ADHD ☐ Down Syndrome ☐ Mentally Retarded ☐ Learning Disorder ☐ Slow Learner

☐ Emotionally up or down ☐ Slow neuromuscular reflex ☐ Multiple sclerosis ☐ Parkinson's ☐ Lou Gehrig's disease (ALS)

☐ Memory decreased for: ☐ Past ☐ Present ☐ Noticeable ☐ Moderate ☐ Mild Explain:

Comments:

EYES and VISUAL

☐ Burn ☐ Dry ☐ Itchy ☐ Red veins ☐ Painful ☐ Watery White of eyes: ☐ Gray ☐ Yellow ☐ Murky

Eyelids: ☐ Discolored: ☐ Blue ☐ Brown ☐ Black ☐ Red ☐ Wrinkled ☐ Puffy: ☐ Above ☐ Below

☐ Injuries: _____ ☐ Contacts ☐ GLASSES: ☐ Sunglasses ☐ Reading ☐ Near-vision ☐ Far-vision

☐ Cataract ☐ Glaucoma ☐ Macular Degeneration SURGERY: ☐ Cataract ☐ Lasik ☐ Other When?

Comments:

EARS and HEARING

☐ Feel full ☐ Earaches ☐ Fluid in ear ☐ Injury ☐ Hearing loss: ☐ Right ear ☐ Left ear ☐ Dizzy with inner ear infection

☐ Feel blocked ☐ Red outer ears ☐ Noise hurts ☐ Ear infections ☐ Surgery: _____ When?_____

Comments:

NOSE, SMELL and SINUSES

☐ Itchy: ☐ Sore: ☐ Inside ☐ Outside ☐ Rub nose ☐ Hayfever ☐ Watery ☐ Post-nasal drip ☐ Sinus pressure

☐ Sneeze: ☐ Often ☐ Loud ☐ Snore ☐ Sniffling ☐ Sinusitis ☐ Nosebleeds ☐ Polyps ☐ Deviated septum

☐ Nose blocked on: ☐ Right ☐ Left ☐ Alternates WORSE: ☐ Warm room ☐ Upright ☐ Lie down ☐ Night ☐ Day

Surgery: ☐ Deviated septum ☐ Sinus ☐ Polyps ☐ Cosmetic ☐ Sinus X-ray ☐ CAT scan When & why?

Describe injury: When? How severe?

Comments:

MOUTH, TEETH, THROAT and VOCAL CORDS

☐ Itchy ☐ Scratchy ☐ Sore often ☐ Swollen ☐ Difficult swallowing ☐ Choke: ☐ Pills ☐ Liquid ☐ Food

☐ Excess salivation ☐ Hoarse ☐ Clear throat often ☐ Mucus on vocal cords ☐ Pills LIPS ☐ Swollen ☐ Dry

Tongue: ☐ Swollen ☐ Coated ☐ Cracked MOUTH: ☐ Bad Breath ☐ Canker sores GUMS: ☐ Recede ☐ Bleed

☐ TMJ ☐ Surgery: ☐ Oral ☐ Tonsils ☐ Adenoids ☐ Thyroid ☐ Gums ☐ Implant # Dental X-rays:_____

☐ Teeth extracted # ___ ☐ Wisdom ☐ Other ☐ Impacted ☐ Cracked ☐ Gum disease ☐ Decay ☐ Amalgam/mercury fillings

Comments:

RESPIRATORY SYSTEM

☐ Asthma ☐ Bronchitis ☐ Chest Tight ☐ Cough frequently ☐ Wheeze with resp.infection ☐ Wheeze without resp. infection

☐ Pneumonia ☐ Quick, short breaths ☐ Feel lack of air: ☐ Walk ☐ Talk ☐ Climb stairs ☐ Climb hill ☐ Sitting

☐ Emphysema ☐ Pleurisy ☐ Need fresh air ☐ Worse if run or walk fast ☐ Other:

Coughs/colds: ☐ Linger ☐ Frequent Result of: ☐ Pollen ☐ Dander ☐ Seasons ☐ Weather changes

☐ Surgery Describe:_____ # Chest X-rays:_____ #Pillows during sleep: _____ ☐ Fluoroscope of chest

Comments:

MUSCLES, BONES AND JOINTS

Muscles: ☐ Weak ☐ Poor control ☐ Wasting ☐ Flabby ☐ Dystrophy ☐ Painful/sore TENSION: ☐ Neck ☐ Back

Joints: ☐ Rheumatic ☐ Arthritis ☐ Stiff ☐ Loose ☐ Hurt before thunderstorm ☐ Bursitis ☐ Fibrositis

Bones: ☐ Osteoporosis ☐ Osteopenia ☐ Spinal curvature ☐ Bone disease ☐ Fractures Explain:

Back: ☐ Injury ☐ Surgery Explain: ☐ X-ray/scan Explain:

Upper limbs ☐ Injury ☐ Surgery Explain: ☐ X-ray/scan Explain:

Lower Limbs ☐ Injury ☐ Surgery Explain: ☐ X-ray/scan Explain:

Comments:

URINARY SYSTEM

Urination: ☐ Urgent ☐ Painful ☐ Frequent: ☐ Day ☐ Night ☐ Lose Urine ☐ Must wait ☐ Press to go ☐ Bed-wetting

Bladder: ☐ Infections ☐ Painful ☐ Spasms ☐ Prolapse ☐ Surgery ☐ Scan ☐ Sonogram ☐ Other:

Kidney: ☐ Infections ☐ Stones ☐ Disease ☐ Surgery: ☐ Scan ☐ Sonogram ☐ Other:

Urine: ☐ Protein ☐ Blood COLOR: ☐ Dark ☐ Light ODOR: ☐ Strong ☐ Acidic ☐ Alkaline ☐ Sweet

Comments:

FEMALE SYSTEM

Menses: ☐ Normal ☐ Regular ☐ Irregular ☐ Long ☐ Intermittent ☐ Short ☐ Too heavy ☐ Light ☐ Clotted

Age began:_____ Age ceased:_____ Result of: ☐ Menopause ☐ Hysterectomy ☐ Excess weight loss

Intercourse: ☐ Painful ☐ Very dry ☐ Aversion Libido: ☐ None ☐ Excess ☐ Low ☐ Normal

Uterus: ☐ Prolapse ☐ Hysterectomy ☐ Fibroids ☐ Infection TUBES: ☐ Tubal pregnancy ☐ Infection ☐ Ligation

Cervix: Pap Smear: ☐ Positive ☐ Negative ☐ Cryosurgery ☐ Erosion ☐ Warts ☐ Other:

Labia: ☐ Pimples ☐ Boils ☐ Red ☐ Bartholin cyst ☐ Warts ☐ Herpes ☐ Itches ☐ Scabs ☐ Other:

Vaginal: Discharge? ☐ White ☐ Yellow ☐ Thick ☐ Burning ☐ Itching ☐ Yeast-like

Ovaries: ☐ Cysts ☐ Tumors ☐ Endometriosis ☐ Surgery Explain: When?

Breasts: ☐ Cysts ☐ Tumors ☐ Benign ☐ Cancer ☐ Surgery ☐ Mastectomy ☐ Biopsy Explain:

☐ Pre-menstrual syndrome: ☐ Swollen ☐ Irritable ☐ Weepy ☐ Anxious ☐ Sore breasts ☐ Headache ☐ Constipated

Pregnancies:_____ ☐ High-risk ☐ Diabetes ☐ Eclampsia ☐ Toxemia ☐ Miscarried:____ ☐ Aborted:____

Deliveries: ☐ Twins ☐ Triplets ☐ Premature ☐ C-section ☐ Vaginal ☐ Breech Live:____ Stillborn:____

Comments:

MALE SYSTEM

Penis: ☐ Scabs ☐ Warts ☐ Herpes ☐ Chancres ☐ DISCHARGE: ☐ Yellow ☐ Green ☐ White

Intercourse: ☐ Aversion ☐ Too quick ☐ Incomplete ☐ Painful LIBIDO: ☐ Low ☐ Excess ☐ Normal ☐ None

Erections: ☐ Weak ☐ Incomplete ☐ Short ☐ Painful ☐ During sleep ☐ Need Rx sex enhancers

Scrotum: ☐ Weak ☐ Itches ☐ Sores ☐ Painful ☐ Herpes ☐ Pimples ☐ Pustules ☐ Jock Itch

Surgery: ☐ Prostate ☐ Testicular ☐ Urethra ☐ Penis Other: When?

Comments:

CHILDHOOD

Infant milk: ☐ Breast ☐ Bottle ☐ Cow's ☐ Goat's ☐ Nutramigen ☐ Enfamil ☐ Soy Other:

Weaned at: _____ mos. ____ yrs. ☐ Projectile Vomiting ☐ Excess milk regurgitation ☐ Colic

☐ Feeding difficulties ☐ Formula change ☐ Foods omitted How long? ____ Improved? ☐ Some ☐ Much ☐ None

Age (mos) began eating: ☐ Grains____ ☐ Juice____ ☐ Sweet____ ☐ Fruit_____ ☐ Cereal_____ ☐ Meat_____ ☐ Veggies_____

Describe any food problems:

☐ Food allergies Explain:

☐ Food intolerance Explain:

First tooth: _____ mos. Sat up: _____mos. Crawled: _____mos. Walked: _____mos. First word:_____mos. Sentences: _____mos.

Comments:

VACCINATIONS

☐ Hepatitis B ☐ Diphtheria ☐ Pertussis: whooping cough ☐ Tetanus ☐ Measles ☐ Mumps ☐ Rubella ☐ Polio

☐ Hemophilus influenzae ☐ Chicken pox ☐ TB ☐ Small pox ☐ Pneumonia ☐ Influenza ☐ Typhoid ☐ Yellow Fever

☐ Vaccine reaction: ☐ Seizures ☐ High fever ☐ Paralysis ☐ High-pitched screams ☐ Other:

Comments:

HOSPITALIZATION and CHRONIC ILLNESS

☐ Hospitalized for illness other than surgery:_____ ☐ Surgical complications:_____

☐ Long confinement from illness ☐ Work disability ☐ Mental Hospital Length of stay:_____ When?

☐ Outpatient surgery Describe: ☐ Complications:_____ When?

Additional and pertinent information:

FAMILY and HEALTH HISTORY

Please put and X in the rows across, if condition has ever applied to blood relative listed in family column (on far left).

If you are adopted, with no knowledge of birth parents check here. ☐

Family Names of close living and deceased relatives	Brother	Sister	Health Status G = Good F = Fair P= Poor	Birth Year	COMMON DISEASES AND DISORDERS Alcoholic/heavy drinker	Allergies/asthma/sinus	Anemia/hemophilia	Arthritis/rheumatism	Lung/emphysema	Cancer/tumor	Diabetes/glands/thyroid	Stomach/colon	Heart/circulation	Hypertension/stroke	Kidney/bladder	Psychiatric disorder	Migraines	Died from	Age now or when died
Yourself																			
Mother																			
Father																			
Maternal grandmother																			
Maternal grandfather																			
Paternal grandmother																			
Paternal grandfather																			

Check family diseases and list only blood relative affected in space provided, using abbreviations below*.

☐ alcoholism _____ ☐ cancer _____ ☐ encephalitis _____ ☐ gonorrhea _____ ☐ malaria _____

☐ Parkinson's _____ ☐ polio _____ ☐ syphilis _____ ☐ tuberculosis _____ ☐ other: _____

*Abbreviations: P: paternal M: maternal G: grand F: father M: mother A: aunt U: uncle GG:great grand i.e.: PGF: paternal grandfather

PRENATAL and BIRTH HISTORY:

Check all applicable during mother's pregnancy with you.

☐ diabetic ☐ hypertension ☐ albumin in urine ☐ kidney infection ☐ German measles ☐ high-risk pregnancy

☐ Tobacco us If so, how many packs a day? ___ ☐ chlamydia ☐ gonorrhea ☐ syphilis ☐ excess alcohol Meds: ☐ Rx ☐ OTC

☐ crack/cocain ☐ marijuana ☐ street drugs ☐ uppers ☐ downers ☐ other ☐ antibiotics ☐ aspirin ☐ hormones

☐ cord around nec ☐ eclampsia ☐ toxemia ☐ premature ☐ C-Section ☐ breech ☐ posterior ☐ face-up ☐ forceps ☐ fetal distress

☐ multiple birt # babies _____ ☐ Difficult delivery Birth weight: ___ lbs. ___ oz. ☐ Rh problem ☐ blood exchange ☐ resuscitated @ birth

☐ vacuum/suctio ☐ other birth difficulties: _____ ☐ # Sonograms: ___ ☐ near miscarriage

☐ incubator ___ ☐ ___ weeks ☐ months # children mother delivered before you? ___ # siblings who died at or shortly after birth?

If patient is a child or is disabled, who is main caregiver? How many children live with you?

CURRENT and PAST MEDICATIONS:	DOSAGE			LENGTH of TIME TAKEN			Allergic?
Acetaminophen (Tylenol)	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Antacid	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Antidepressant(s)	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Aspirin (Ecotrin or Bufferin)	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Ibuprofen (Advil, Nuprin, or Motrin)	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Laxative(s): ☐ Vegetable ☐ Herbal ☐ Other	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Nebulizer	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Nose drops or spray	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Sinus or allergy medicine	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Skin ointment or cream	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2+ yrs.	☐ Yes
Oral steroids: Prednisone/Decadron/Medrol/Other	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	☐ Yes
IV steroids: Depo Medrol/Decadron/Kenalog/Other	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	☐ Yes
Birth control pill/estrogen/progesterone/testosterone	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2+ yrs.	☐ Yes
Ampicillin, Amoxicillin or Penicillin	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Ceclor	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Erythromycin	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Keflex	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Streptomycin	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Tetracycline(s)	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes
Other:	☐ Daily	☐ 1-2/wk	☐ As needed	☐ 1-6 mo.	☐ 6-12 mo.	☐ 2^+ yrs.	☐ Yes

REASONS FOR ANTIBIOTIC USE:	YEAR	or AGE	LENGTH of TIME TAKEN			COMMENTS
☐ Acne or other skin infection			☐ 1-2 wks.	☐ 1-11 mos	☐ 1^+ yrs.	
☐ Bronchitis or pneumonia			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	
☐ Colds or sinus infection			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	
☐ Ear infection			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	
☐ Influenza or after-effects of flu			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	
☐ Kidney, bladder, prostate infection			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	
☐ Tonsillitis or strep throat infection			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	
☐ Surgical or dental-related problem			☐ 1-2 wks.	☐ 1 mo.	☐ 2^+ mo.	

Do you experience symptoms in weather listed below?				COMMENTS
Clear, sunny days	☐ Better	☐ Worse	☐ Don't know	
Cold, dry weather	☐ Better	☐ Worse	☐ Don't know	
Cold, damp weather	☐ Better	☐ Worse	☐ Don't know	
Warm or hot dry weather	☐ Better	☐ Worse	☐ Don't know	
Warm or hot humid weather	☐ Better	☐ Worse	☐ Don't know	
During rainy or humid weather	☐ Better	☐ Worse	☐ Don't know	
Before or during a thunderstorm or storm front	☐ Better	☐ Worse	☐ Don't know	
From wind: ☐ Cold ☐ Warm ☐ Stormy	☐ Better	☐ Worse	☐ Don't know	
Outdoors: 7 to 10:00 AM	☐ Better	☐ Worse	☐ Don't know	
Outdoors: 4:30 to 8:30 PM	☐ Better	☐ Worse	☐ Don't know	
Outdoors: cool evening air	☐ Better	☐ Worse	☐ Don't know	
Outdoors: hot weather	☐ Better	☐ Worse	☐ Don't know	
Heavy (killing) frost (Sep-Nov)	☐ Better	☐ Worse	☐ Don't know	
Weather change: ☐ Warm to cold ☐ Cold to warm	☐ Better	☐ Worse	☐ Don't know	
Fall temperatures (Oct-Nov)	☐ Better	☐ Worse	☐ Don't know	
Comments:				

How do you feel in situations listed below?		COMMENTS
Artificially heated air	☐ Better ☐ Worse ☐ Don't know	
Indoors, especially if air-conditioned	☐ Better ☐ Worse ☐ Don't know	
Outdoors from air-conditioning	☐ Better ☐ Worse ☐ Don't know	
In a damp basement	☐ Better ☐ Worse ☐ Don't know	
Damp or moldy (indoors or outdoors)	☐ Better ☐ Worse ☐ Don't know	
Dusting or sweeping	☐ Better ☐ Worse ☐ Don't know	
In certain homes--Please explain:	☐ Better ☐ Worse ☐ Don't know	
Thirty (30) mins after going to bed	☐ Better ☐ Worse ☐ Don't know	
Around cats or where they have been	☐ Better ☐ Worse ☐ Don't know	
Around dogs or where they have been	☐ Better ☐ Worse ☐ Don't know	
Around other animals--Please specify:	☐ Better ☐ Worse ☐ Don't know	
In a feed mill or barn	☐ Better ☐ Worse ☐ Don't know	
Rake or play in leaves	☐ Better ☐ Worse ☐ Don't know	
Does whole eyeball itch?	☐ Yes ☐ No ☐ Don't know	
Do inner corners of eyes itch?	☐ Yes ☐ No ☐ Don't know	
Have nasal symptoms if mow or play on grass?	☐ Yes ☐ No ☐ Don't know	
Do you sneeze, have runny, or itchy nose?	☐ Yes ☐ No ☐ Don't know	
Have nasal symptoms w/o itchy, watery eyes?	☐ Yes ☐ No ☐ Don't know	
Please indicate the months you are better or worse.		**COMMENTS**
January	☐ Better ☐ Worse ☐ Don't know	
February	☐ Better ☐ Worse ☐ Don't know	
March	☐ Better ☐ Worse ☐ Don't know	
April	☐ Better ☐ Worse ☐ Don't know	
May	☐ Better ☐ Worse ☐ Don't know	
June	☐ Better ☐ Worse ☐ Don't know	
July	☐ Better ☐ Worse ☐ Don't know	
August	☐ Better ☐ Worse ☐ Don't know	
September	☐ Better ☐ Worse ☐ Don't know	
October	☐ Better ☐ Worse ☐ Don't know	
November	☐ Better ☐ Worse ☐ Don't know	
December	☐ Better ☐ Worse ☐ Don't know	
Spring	☐ Better ☐ Worse ☐ Don't know	☐ Least bothered ☐ Most bothered
Summer	☐ Better ☐ Worse ☐ Don't know	☐ Least bothered ☐ Most bothered
Autumn	☐ Better ☐ Worse ☐ Don't know	☐ Least bothered ☐ Most bothered
Winter	☐ Better ☐ Worse ☐ Don't know	☐ Least bothered ☐ Most bothered
Symptoms worse year-round	☐ Yes ☐ No ☐ Don't know	

HOME ENVIRONMENT

Live in: ☐ House ☐ Wooded Area ☐ Apt. ☐ Farmhouse ☐ Mobile Home YEAR BUILT:

Type of dwelling: ☐ Single ☐ Duplex ☐ Apt. ☐ One-Story ☐ Two-Story ☐ Breezeway

☐ Garage ☐ Attached ☐ Detached ☐ Finished ☐ Unfinished ☐ Laundry Area ☐ Water Heater

☐ Basement: ☐ Damp ☐ Dry ☐ Musty ☐ Unfinished ☐ Finished ☐ Laundry Area

Foundation: ☐ Concrete slab ☐ Pier & Beam ☐ Crawl space ☐ Plywood sub-floor: ☐ 1st floor ☐ 2nd floor

Floors: Kitchen & Dining: ☐ Wood ☐ Carpet ☐ Tile ☐ Linoleum BEDROOMS: ☐ Wood ☐ Carpet ☐ Tile

Living Areas: ☐ Tile ☐ Wood ☐ Carpet ☐ Linoleum ☐ Finished concrete

☐ New Carpet When? Which rooms?

☐ Feel worse in one or more rooms Explain:

HOME ENVIRONMENT (Cont.)

Water heater: ☐ Gas ☐ Electric Cook with: ☐ Gas ☐ Wood ☐ Electric DRY CLOTHES: ☐ Line Dry ☐ Electric ☐ Gas

Water source: ☐ Well ☐ City ☐ Store Plumbing: ☐ Lead pipes ☐ PVC DRINK: ☐ Distilled ☐ Filtered ☐ Deionized ☐ Other

Air Conditioner: ☐ Central air ☐ Attic blower ☐ Interior Closet ☐ Window Unit ☐ Swamp Cooler ☐ Other:

Heat type? ☐ Electric ☐ Gas ☐ Central ☐ Wall ☐ Floor ☐ Fuel Oil ☐ Burn Wood ☐ Steam ☐ Radiator ☐ Coal

Insulation: ☐ Styrofoam ☐ Cellulose (ground-up paper) ☐ Fiberglass ☐ Sawdust ☐ Tyvek wrap ☐ Other:

☐ UTTI (ureafoam) When was it insulated? ☐ Live near power lines ☐ Live near freeway

☐ Newly painted house When? PAINT: ☐ Regular Latex ☐ Hypoallergenic/Low Odor ☐ Oil-Based

☐ Recently remodeled Describe work done:

☐ Ceiling fans ☐ Bedroom ☐ On during sleep ☐ Living areas

Air filter: ☐ HEPA ☐ Electronic ☐ Fiberglass ☐ Ozone ☐ Other:

☐ Humidifier ☐ On furnace or ☐ Room unit MOLD: ☐ Now ☐ Past Where?

☐ Air Purifier ☐ Portable BRAND:_____ Which rooms?

Tobacco use: ☐ Never ☐ Now ☐ Past ☐ Patient ☐ Spouse ☐ Father ☐ Mother ☐ Cigar ☐ Cigarette ☐ Pipe

☐ Quit smoking? ☐ Short time ☐ Permanently How long? When?

☐ Use moth balls/crystals ☐ Pest control ☐ Often ☐ Rare ☐ Cause symptoms Describe:

☐ Flea spray: pets/house ☐ Cause symptoms Explain:

Patient or family hobbies: ☐ Ceramics ☐ Garden ☐ Wood Working ☐ Auto Repair ☐ Stain Glass ☐ Other:

List new furnishings:

MATTRESS: ☐ Latex ☐ Regular ☐ Cotton MATTRESS COVER: ☐ Cotton ☐ Polyester/Synthetic ☐ Hypo-allergenic

Bed pillows: ☐ Dacron ☐ Feather ☐ Cotton ☐ Polyester ☐ Other: BED SHEETS: ☐ Polyester ☐ Cotton ☐ Silk

Bedcover: ☐ Wool ☐ Cotton ☐ Down ☐ Polyester ☐ Allergy proof ☐ Other:

☐ Stuffed animals ☐ Sleep with them ☐ Cause symptoms

Current pets: How long? _____ yrs._____ mos. From:_____ to_____

Past pets: How long? _____ yrs._____ mos. From:_____ to_____

☐ Animals in the past ☐ By previous owner Explain:

☐ Away from home environment recently? FELT: ☐ Same ☐ Some better ☐ Much better Explain:

Where did you go? ☐ Tropics ☐ Island ☐ Cool ☐ Hot ☐ Mountains ☐ Ocean ☐ Ski/Snow ☐ Humid ☐ Dry

☐ Change in climate alleviated symptoms. Explain:

Comments:

WORK ENVIRONMENT

☐ Symptoms at work? from: ☐ Machines ☐ Materials ☐ Tobacco smoke Which area(s)?

At work feel: ☐ Same ☐ Better ☐ Worse How long at job? _____ mos._____yrs. Air travel _____ times a year

How many miles to job? _____ Miles VIA: ☐ Expressway ☐ Airplane ☐ City Streets ☐ Exposed to heavy exhaust

Exposures: ☐ Now ☐ Past ☐ Fumes ☐ Cotton dust ☐ Grain dust ☐ Chemicals ☐ Asbestos ☐ Agricultural Sprays

☐ Biologicals: Blood/Serum/Toxins ☐ Mold ☐ Petrochemicals ☐ Formaldehyde ☐ Phenol ☐ Spray paint ☐ Other:

Comments:

SOCIAL AND OTHER ENVIRONMENT

Feel sick in a: ☐ New car ☐ Older car ☐ Church ☐ School ☐ Gas station ☐ Shopping Mall ☐ Fabric store ☐ Home Center store

☐ Barber or beauty shop ☐ Clinic or Hospital ☐ Clothing store ☐ Carpet or Furniture store ☐ Other:

Describe symptoms and probable cause:

List industries near home:

Feel sick from: ☐ Bleach ☐ Ammonia ☐ Asphalt ☐ Roof or road tar ☐ Asbestos ☐ Chlorine ☐ Cosmetics ☐ Disinfectant Spray

☐ Gas/Petroleum Products ☐ Exhaust fumes ☐ Fabric Softeners ☐ Floor Wax or Polish ☐ Gas ☐ Hair Spray ☐ Insecticides

☐ Moth Balls ☐ Newsprint/Books ☐ Perfume ☐ Rubber Products ☐ Soap or Detergent ☐ Tobacco Smoke ☐ Varnish or Paint

☐ Metal allergy to: ☐ Costume jewelry ☐ Gold ☐ Silver ☐ Titanium ☐ Nickel ☐ Other:

Comments:

ADDITIONAL HEALTH HISTORY INFORMATION

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

JOHNSON MEDICAL ASSOCIATES

ALLERGY TESTING ROOM PROTOCOL

JOHNSON MEDICAL ASSOCIATES offers a **GROUP TYPE** of **ALLERGY SENSITIVITY TESTING** because it is the most cost-effective way of providing services to more patients at one time. This type of testing structure requires **SEVERAL PATIENTS** to be **IN THE SAME ROOM TOGETHER** over a period of hours and sometimes days or weeks. Consequently, we have developed protocol to facilitate your experience, and result in a productive, positive outcome in a healing atmosphere.

At **JMA**, we respect people of all races, ethnic backgrounds, religious beliefs, etc. and do our best to treat all equally. As our guest, your respectful treatment of others is much appreciated. Thank you for your cooperation, patience and understanding in this matter. Our testing supervisor will be happy to answer any questions you might have regarding the following:

1. **AVOID** the use of any scented products in the testing rooms and **JMA** clinic such as:
   - Clothes that were washed in scented detergent with fabric softener
   - Perfumed soap, scented hair spray/deodorant, powder, perfume or cologne
   - Clothes with tobacco, dry-cleaning or perfume residue
   - **PLEASE REFER TO OUR** *SAFE PRODUCTS LIST* **FOR UNSCENTED PRODUCTS AVAILABLE**
2. If the odor is too strong for others, you may need to shower and change into scrubs.
3. Please schedule another appointment if the shower and scrubs do not help.
4. Bottled water is allowed; but all other food and drink is prohibited.
5. Newspapers or reading material with a strong smell of ink are not allowed.
6. **PERSONAL BELONGINGS** (purses, bags, briefcases) need to be in the **LOCKERS PROVIDED**.
7. Shoes must be worn at all times.
8. **CELL PHONES**, **COMPUTERS** and other electronic devices are limited to non-patient areas.
9. Please leave the testing room in the same condition as you found it.
10. **PLEASE DO NO LOITER IN THE JMA HALLWAYS** or at the **NURSE'S STATION**. Wait in the waiting room until you are called in to begin testing or for your appointment with the doctor.
11. Children and Testing:
    - Minor children (under 18) must be attended at all times
    - Only children who are being tested are allowed in the testing room
    - Siblings will need other arrangements for care
    - One Parent or Guardian with one child at a time is generally preferable
    - Running, jumping, and loud voices are not allowed
    - Parents: see that toys provided are picked up before leaving
    - Keep children's testing room door closed at all times

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SAFE PRODUCTS SUPPLY LIST

Products on this list are reportedly **tolerated by many of our patients**, and it is our hope that it will enable to find products you can use safely, although we neither endorse nor recommend them. We are aware that sensitivities are individual and what works for one person may not work for another. This list is provided as a courtesy to you, and may serve as a possible starting point in your efforts to find products for personal care that will at least cause no further problems. If you have knowledge about other safe products you have used, please let us know so we can try them and add them to our future lists. **NOTE OF ADVICE:** AVOID DEODORANT TYPE SOAP

SOAP: PERSONAL CARE	SPECIAL NOTES	TYPE	DISTRIBUTOR	SOURCES
AVEENO SKIN RELIEF BODY WASH	FRAGRANCE FREE	LIQUID	JOHNSON & JOHNSON	SUPERMARKET OR PHARMACY
DOVE	SENSITIVE SKIN FORMULA **ONLY**!	BAR/LIQUID	UNILEVER	SUPERMARKET OR PHARMACY
GREEN PERSONAL CARE CLEANER	HAND/BATH/DELICATE CLOTHES	LIQUID	GOLDEN NEO-LIFE DIAM	JMA/uslink.net/~golden/order1.html
IVORY	UNSCENTED	BAR/LIQUID	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
MOISTURE SOAP (KISS MY FACE)	FRAGRANCE FREE	LIQUID	kissmyface.com	HEALTH FOOD-SUPERMARKET-ONLINE
OLAY BEAUTY BAR	UNSCENTED	BAR	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
SIMPLE GREEN	ALL PURPOSE CLEANER	LIQ/FM/SPRY	APACHE CHEMICAL	ACE HWDE, SAM'S & SUPERMARKETS
SOAP: LAUNDRY	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCES**
20 MULE TEAM BORAX	BORON, SODIUM, WATER, OXYGEN	POWDER	US BORAX INC.	SUPERMARKET OR PHARMACY
ALL FREE CLEAR	NO DYES OR FRAGRANCE	LIQUID	LEVER BROS	SUPERMARKET
ARM & HAMMER WASH	UNSCENTED	PWD/LIQ	CHURCH/DWIGHT	SUPERMARKETS
BASIC L	NO DYE OR FRAGRANCE	POWDER	SHAKLEE	LOCAL DISTRUTOR
CHEER COLOR GUARD FREE GENTLE	NO DYE OR FRAGRANCE	LIQUID	LEVER BROS.	SUPERMARKET OR PHARMACY
DREFT (SODIUM LAURYL SULFATE)	NO DYE OR FRAGRANCE	PWD/LIQ	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
IVORY SNOW	NO DYE OR FRAGRANCE	LIQUID	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
NEO LIFE	NO DYE OR FRAGRANCE	POWDER	GOLDEN NEO-LIFE DIAM	SPECIAL ORDER
PUREX FREE CLEAR	NO DYE OR FRAGRANCE	LIQUID	DIAL CORP.	SUPERMARKET OR PHARMACY
SA8	NO DYE OR FRAGRANCE	LIQUID	QUIXTAR	LOCAL DISTRIBUTOR
TIDE-FREE	NO DYE OR FRAGRANCE	LIQUID	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
FABRIC SOFTENERS	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCES**
APPLE CIDER VINEGAR	USE IN RINSE CYCLE	LIQUID	VARIOUS	HEALTH FOOD OR SUPERMARKET
BAKING SODA	USE IN RINSE CYCLE	POWDER	VARIOUS	SUPERMARKET OR PHARMACY
BOUNCE	UNSCENTED	SHEETS	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
DOWNY FREE AND SENSITIVE	UNSCENTED	LIQUID	PROCTOR-GAMBLE	WALMART-TARGET-SUPERMARKET
SHAMPOO: HAIR	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCES**
DHS SAL (3% SALICYLIC ACID)	SEBORRHEA/PSORIASIS/NO SCENT	LIQUID	PERSON & COVEY	PERSON & COVEY, INC.
DHS CLEAR	UNSCENTED & COLOR FREE	LIQUID	PERSON & COVEY	PERSON & COVEY, INC.
EVERCLEAN ANTI-DANDRUFF	UNSCENTED	LIQUID	HOME HEALTH PROD	HEALTH FOOD-SUPERMARKET-ONLINE
MILL CREEK	RINSE WELL	LIQUID	MILL CREEK BOTANICALS	HEALTH FOOD-SUPERMARKET-ONLINE
RICH & RADIANT:GRANNY'S OLD F.	UNSCENTED	LIQUID	www.lassentech.com	HEALTH FOOD-SUPERMARKET-ONLINE
SUAVE NATURALS: ALOE VERA	VERY LOW SCENT	LIQUID	UNILEVER	SUPERMARKET OR PHARMACY
HAIR CONDITIONERS	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCES**
AU NATURELLE ORG-NATURE CLEAN	FRAGRANCE FREE	LIQUID	www.franktross.com	HEALTH FOOD-SUPERMARKET-ONLINE
PURE ESSENTIALS	FRAGRANCE FREE	LIQUID	EARTH SCIENCE INC.	HEALTH FOOD-SUPERMARKET-ONLINE
SOFT AND SILKY: GRANNY'S OLD F.	FRAGRANCE FREE	LIQUID	www.lassentech.com	HEALTH FOOD-SUPERMARKET-ONLINE
SUAVE NATURALS: ALOE VERA	VERY LOW SCENT	LIQUID	SUAVE	SUPERMARKET OR PHARMACY

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HAND AND BODY LOTION	SPECIAL NOTES	TYPE	DISTRIBUTOR	SOURCE
ALMAY PROBLEM SOL ANTI-IRRITANT	FRAGRANCE FREE	LOTION	ALMAY OR almay.com	SUPERMARKET OR PHARMACY
ALPHA ALOE OIL FREE (KISS MY FACE)	FRAGRANCE FREE	LOTION	kissmyface.com	HEALTH FOOD OR ONLINE
ST IVES INTENSIVE THERAPY	FRAGRANCE FREE	LOTION	ST. IVES CORP	SUPERMARKET OR PHARMACY
ST. IVES COLLAGEN & ELASTIN	FRAGRANCE FREE	LOTION	ST. IVES CORP	SUPERMARKET OR PHARMACY
ULTRA HEAL INTENS MOIST THERAPY	FRAGRANCE FREE	LOTION	JERGEN'S	SUPERMARKET OR PHARMACY
VASELINE CREAMY PROT. SKIN THER	UNSCENTED	LOTION	VASELINE	SUPERMARKET OR PHARMACY
VASELINE INTENS CARE EXTRA STRENGTH	UNSCENTED	LOTION	VASELINE	SUPERMARKET OR PHARMACY
DEODORANTS	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCE**
ALMAY	UNSCENTED	SOLID	ALMAY OR almay.com	SUPERMARKET OR PHARMACY
ARM & HAMMER	UNSCENTED	SOLID	CHURCH & DWIGHT	SUPERMARKET OR PHARMACY
ARRID 4X	UNSCENTED	SOLID	CHURCH & DWIGHT	SUPERMARKET OR PHARMACY
CRYSTAL: STICK/GEL/SPRAY	NO ALUMINUM CHLORHYDRATE	GEL/SPRAY	PT LTD	SUPERMARKET OR PHARMACY
MENNEN SPEED STICK ANTI-PERSPIRANT	UNSCENTED	SOLID	COALGATE PALMOLIVE	SUPERMARKET OR PHARMACY
MITCHUM: CLEAR GEL, & SOLID	UNSCENTED	CLEAR GEL	REVLON	SUPERMARKET OR PHARMACY
OLD SPICE RED ZONE: ROLL-ON/GEL	UNSCENTED	SOLID/SPRAY	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
SECRET: ROLL-ON/SPRAY/GEL/SOLID	UNSCENTED	VARIOUS	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
SURE: ROLL-ON/SPRAY/GEL/SOLID	UNSCENTED	VARIOUS	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
TOM'S NATURAL DEODORANT	UNSCENTED	SOLID	TOM'S OF MAINE	SUPERMARKET OR HEALTH FOOD
SHAVING CREAMS/GEL	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCE**
EDGE PRO GEL	FRAGRANCE FREE	SOLID	SC JOHNSON	SUPERMARKET OR PHARMACY
KISS MY FACE: EXTRA SENS SKIN	FRAGRANCE FREE	SOLID	kissmyface.com	HEALTH FOOD-SUPERMARKET-ONLINE
HAIR SPRAY	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCE**
CLASSIC HAIR SPRAY	Unscented	SPRAY	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
FINESSE NON-AEROSOL & AEROSOL	UNSCENTED	SPRAY	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
JHIRMACK EXTRA HOLD	UNSCENTED	SPRAY	PLAYTEX BEAUTY	SUPERMARKET OR PHARMACY
PANTENE PRO-V HAIR SPRAY	UNSCENTED	SPRAY	PROCTOR-GAMBLE	SUPERMARKET OR PHARMACY
RAVE	UNSCENTED	SPRAY	SUAVE	SUPERMARKET OR PHARMACY
SUAVE	UNSCENTED	SPRAY	SUAVE	SUPERMARKET OR PHARMACY
WHITE RAIN	UNSCENTED	SPRAY	GILLETTE	SUPERMARKET OR PHARMACY
HAIR GEL OR MOUSE	**SPECIAL NOTES**	**TYPE**	**MADE BY**	**SOURCE**
CLINIQUE HAIR GEL	FRAGRANCE FREE	GEL	CLINIQUE	DEPARTMENT STORE
ALL PURPOSE CLEANERS	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCE**
ALL PURPOSE CLEANER	ENVIRONMENTALLY SAFE	FOAM/SPRAY	SHAKLEE	SHAKLEE DISTRIBUTOR
SAFE CHOICE SUPER CLEAN	CLEANER & DEGREASER	LIQUID	AMF/AMER MANU FORM	SPECIAL ORDER
AT-EASE HEAVY DUTY SCOURING	OVENS, STOVETOPS, BBQ GRILL	PASTE	SHAKLEE	SHAKLEE DISTRIBUTOR
BASIC-I (GREASE-CUTTING)	ENVIRONMENTALLY SAFTE	LIQUID	SHAKLEE	SHAKLEE DISTRIBUTOR
SATIN-SHEEN CONC. DISHWASHING	UNSCENTED/NO PHOS/NITR	LIQUID	SHAKLEE	SHAKLEE DISTRIBUTOR
COSMETICS	**SPECIAL NOTES**	**TYPE**	**DISTRIBUTOR**	**SOURCE**
FOUNDATION, LIPSTICK ETC.	FRAGRANCE FREE	LIQ/PWD	ALMAY OR almay.com	SUPERMARKET OR PHARMACY
FOUNDATION, LIPSTICK ETC	FRAGRANCE FREE	LIQ/PWD	CLINIQUE	DEPARTMENT STORE
FOUNDATION, LIPSTICK ETC	FRAGRANCE FREE	LIQ/PWD	CLARION	SUPERMARKET OR PHARMACY
HIGH DIMENSION HAIR COLORS	WELL-TOLERATED	LIQUID	REVLON	SUPERMARKET OR PHARMACY
FOUNDATION, LIPSTICK ETC.	HYPO-ALLERGENIC	LIQ/PWD	PHYSICIANS FORMULA	SUPERMARKET OR PHARMACY

JMASafe:Prod:Init:1/00Rev:8/04:jjph