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ADULT AND CHILDHOOD
ASTHMA AND ALLERGY

PHYSICIANS ARE ALL BOARD CERTIFIED BY **THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY**

Boise Valley
Asthma & Allergy
Clinic

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MERIDIAN, IDAHO 83642

SATELLITE CLINICS IN EAGLE, NAMPA AND CALDWELL

bvaac.com

Dear _____,

Welcome to Boise Valley Asthma and Allergy Clinic! We are very pleased that you have chosen us for your source of allergy/asthma care. Enclosed in this packet you will find information about our practice, financial information, medical history, and personal forms.

What to Expect

- Please schedule enough time. In order for us to provide the best and most complete care, the first visit may take up to two hours.
- A parent/guardian must accompany children **less than 18 years of age**.
- The main goal of your first visit is to help us gain a comprehensive understanding of your medical condition. This visit will include a detailed history, physical exam (in most cases), skin testing, and a breathing test for some patients.
- We will review our findings with you at the end of your first visit or at your next appointment. At this time, we will make recommendations and plan a course of action. We encourage you to ask questions and even bring a spouse or family member.
- Your allergist will perform a very thorough evaluation of your condition. The physician/clinician component of the allergy/asthma evaluation will cost between $200.00 and $500.00. Other testing, such as skin tests or pulmonary function test may be necessary and are charged in addition to your evaluation. It is your responsibility to check your insurance coverage and benefits prior to your appointment. If your insurance requires a referral from your primary care physician, you must bring that with you. This also applies to Medicaid Healthy Connections.

What to Bring to the First Visit

- Please complete and bring the following **three forms** as well the other items listed below. The forms may have been sent to you in the mail. They can also be printed from our website **BVAAC.COM**. (Click on the button entitled **Print Forms** in the upper right hand corner and then click on **New Patient Packet.)**

Allergy and Asthma Personal History Form

New Patient Information Form

Financial Form

- **Photo ID**
- **Insurance card**

- **Copies of previous allergy/asthma tests, evaluations and other relevant records.** Be sure to bring copies of any recent blood allergy tests as well as skin tests. It may also be helpful to bring in asthma devices such as inhalers, spacers, and peak flow meters.

- **A list of medications and the dosage that you currently take.** Feel free to bring your medications, inhalers, sprays, asthma spacers, peak flow meters, etc.

Medications to Avoid for Allergy Skin Testing

Antihistamines interfere with skin testing. You will need to stop taking most antihistamines for several days before testing. **If you find it difficult to avoid antihistamines, come to your appointment anyway.** We can still treat your allergic/asthmatic condition and do blood allergy tests and/or skin test at a later date if indicated. **There is no need to stop asthma medications (including asthma inhalers, Singulair, and oral prednisone) and topical steroid nose sprays before skin testing.**

The following are guidelines for avoiding antihistamines before skin testing. **Feel free to call us at (208) 378-0080 with any questions!**

- **Prescription antihistamines** — stop **seven days** prior to appointment.
- **Over-the-counter non-sedating antihistamines** Cetirizine (Allertec, Zyrtec), Loratidine (Alavert, Claritin, etc.) — stop **seven days** prior to appointment.
- **All other over-the-counter antihistamines** — stop **24-72 hours** prior to appointment.
- **Astelin, Astepro, and Patanase Nose Spray**— stop **three days** prior to appointment.
- **Hydroxyzine (Atarax, Vistaril)**—stop **seven days** prior to appointment.
- **Benzodiazepines:** Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam) — stop **seven days** prior to appointment.
- **H-2 blockers:** Axid (nizatadine), Pepcid (famotadine), Tagamet (cimetidine), Zantac (ranitidine) — stop **one day** prior to appointment.
- **Tricyclics/Tetracyclics:** amitryptiline, Norpramin (desipramine), Pamelor (nortriptyline), Remeron (mirtazapine), Seroquel (quetiapine), Sinequan (doxepin), Tofranil (imipramine)— **stop seven days prior to appointment after getting permission from your primary care clinician!**

Follow-up care

Regular follow-up visits are needed for ongoing management. A recheck on at least a yearly basis is needed for to monitor progress, renew/change medications, as well as provide ongoing education. More frequent follow-up may be needed for some conditions such as persistent asthma, severe hay fever, etc.

Keep in Mind

A block of the doctor's time is reserved for your first appointment. Our office will contact you by phone 24 hours prior to your visit to confirm the appointment. You may not reschedule if a cancellation notice is not given. **If you need to reschedule or cancel an appointment, please call our office at (208) 378-0080.**

Thank you very much for choosing us!

Boise Valley Asthma and Allergy Clinic

ALLERGY AND ASTHMA HISTORY

Patient: Please fill out this side

Name _____

Date _____ Date of Birth _____ Age _____

Phone: Home _____ Work _____ **Sex M / F**

Cell: _____ Email: _____

Address _____

City, State, Zip _____

Occupation/grade level _____

Primary Care Clinician _____

Pharmacy _____

Referral source (MD,NP, **phone book, internet, insurance, other)**

_____

Recent Lab: ❑ yes ❑ no If yes, where: _____

The main reasons for coming here are:

_____

_____

_____

At what age did this first occur? _____

What are the goals that you wish to achieve here?

_____

_____

_____

Symptoms:

LUNGS/RESPIRATORY SCREENING TEST

In the past 12 months, have you had:

❑ Recurrent episodes of wheezing or shortness of breath
❑ Colds that go to the chest
❑ Coughing, wheezing or short/tightness with colds, animals, or exercise
❑ A need for medication to help breathing

In the past 4 weeks, have you had cough, wheezing or shortness of breath:

❑ That has awakened you at night/early morning
❑ After running/physical activity
❑ History of Asthma in the past

*If you answered yes or have asthma, fill out the **Asthma Questionaire**, otherwise go to the next page.*

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Meridian, Idaho 83642

(208) 378-0080

Satellite Clinics: Eagle, Nampa, & Caldwell

Asthma Questionaire:

ASTHMA SYMPTOMS/CURRENT CONTROL

Age Asthma symptoms started: _____

Age Asthma was diagnosed: _____

Asthma symptoms: _____

❑ Cough ❑ Wheezing ❑ Shortness of breath
❑ Chest tightness ❑ Increased sputum
❑ These symptoms occur at night/early morning
❑ Is you asthma getting worse over time? ❑ Yes ❑ No

HISTORY OF EARLY LUNG INJURY:

❑ Premature birth ❑ Home use oxygen ❑ 2nd hand smoke
❑ Pneumonia/bronchitis ❑ Chemical lung injury

PATTERN OF SYMPTOMS:

Worse Season:
❑ Spring ❑ Summer ❑ Fall ❑ Winter ❑ Year round

How often do you have Symptoms? _____ X per
❑ Week ❑ Month ❑ Year

PRECIPITATING/AGGRAVATING FACTORS:

❑ Colds/URI ❑ Sinusitis ❑ Allergies ❑ Animals
❑ Dust ❑ Cold air ❑ Night time ❑ Stress ❑ Pollution
❑ Smoke ❑ Fragrance/odors ❑ Exercise ❑ Workplace
❑ School ❑ Weather changes
❑ Drugs (aspirin/beta blockers etc.)
❑ Endocrine factors(menses, pregnancy, thyroid)

Other: _____

Do your asthma symptoms improve when you are on vacation for over a week? ❑ Yes ❑ NO

Physician Notes:

_____

_____

_____

COUGH ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Continuous
- ❑ Day time
- ❑ Night time
- ❑ Barking
- ❑ Interferes with sleep
- ❑ Dry with no sputum
- ❑ With sputum
- ❑ Deep
- ❑ Exercise makes worse

NOSE ❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Nasal congestion
- ❑ Itching
- ❑ Sneezing
- ❑ Post nasal drainage
- ❑ Headaches
- ❑ Bad breath
- ❑ Facial discomfort
- ❑ Clear discharge
- ❑ Thick discharge
- ❑ Mouth breathing
- ❑ Snoring
- ❑ Nose bleeds
- ❑ Rubbing of nose
- ❑ Complete loss of sense of smell

ARE THESE SYMPTOMS WORSE (If no, go to the next section)

Spring ❑ Summer ❑ Fall ❑ Winter ❑

Exposure To:

❑ Animals ❑ Irritants ❑ Pollens/Molds ❑ Other_____

EYES ❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Itching
- ❑ Running
- ❑ Swelling
- ❑ Redness

THROAT ❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Itching
- ❑ Loss of voice (hoarseness)
- ❑ Lump in throat/ throat closing
- ❑ Sore throat
- ❑ Throat clearing
- ❑ Regurgitation of food into throat

EARS ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Popping
- ❑ Itching
- ❑ Hearing loss
- ❑ Dizzy
- ❑ Infections

FOOD ALLERGIES/SYMPTOMS ASSOCIATED WITH EATING A CERTAIN FOOD ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Itching of mouth or throat
- ❑ Swollen lips/tongue
- ❑ Hoarseness/change of voice
- ❑ Hives/swelling
- ❑ Nasea, vomiting, diarrhea or cramps
- ❑ Wheezing/shortness of breath
- ❑ Loss of consciousness
- ❑ Light headed

Foods suspected of causing allergic reaction:

_____

_____

_____

POSSIBLE ACID REFLUX/THROAT REFLUX ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Heartburn
- ❑ Regurgitation of food into throat
- ❑ Acid taste in mouth
- ❑ Throat Clearing
- ❑ Hoarseness
- ❑ Sore throat

Physician Notes:

HIVES OR URTICARIA (WELTS)

❑**Yes** ❑ **No** (If no, go to the next section)

Describe the appearance (size, location):_____

_____

Will scratching cause the hives? ❑ **Yes** ❑ **No**

Frequency: _____

Associated symptoms:

- ❑ Itching
- ❑ Bruising
- ❑ Swollen lips
- ❑ Joint aches
- ❑ Stomach pain
- ❑ Pain
- ❑ Pigment afterwards
- ❑ Last >24 hours
- ❑ Wheezing
- ❑ Fever

Possible trigger factors:

- ❑ Medications (Rx/OTC)
- ❑ Pressure
- ❑ Heat
- ❑ Emotion
- ❑ Food supplements
- ❑ Cold
- ❑ Exercise

DERMATITIS or ECZEMA (rash)

❑**Yes** ❑ **No** (If no, go to the next section)

Describe the appearance: _____

_____

Location:_____

Age of onset:_____

- ❑ Itching
- ❑ Weeping

Possible trigger factors:

- ❑ Foods
- ❑ Medications
- ❑ Animals

ALLERGY TO INSECT STINGS/Does not include other bug bites

❑ **Yes** ❑ **No** (If no go to the next section)

- ❑ Local reaction
- ❑ Hives
- ❑ Cough/wheezing
- ❑ Loss of consciousness/light headed
- ❑ Large Swelling
- ❑ Other:_____

Suspected insect:

- ❑ Honey bee
- ❑ Hornet
- ❑ Other
- ❑ Yellow Jacket
- ❑ Wasp
- ❑ Fire Ants

Site of sting:_____

Onset of symptoms:_____

Duration of symptoms:_____

Medications used:_____

FREQUENT INFECTIONS

❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Chronic infections
- ❑ Incomplete clearing of infection
- ❑ Severe skin rashes
- ❑ Growth failure
- ❑ Recurrent infections
- ❑ Poor response to treatment
- ❑ Chronic Diarrhea
- ❑ Other:_____

Location of infection:

- ❑ Pneumonia
- ❑ Sinus infections
- ❑ Ear infections
- ❑ Skin
- ❑ Other:_____

Physician Notes:

All current medicines: (please include all inhalers & sprays, as well as any herbs/supplements/alternative medicines and CPAP)

Medication	Please include dose:			Physicians Notes
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____

Please list all medications that you have taken in the last two years.

Asthma medication you have used in the past:_____Antihistamines used in the past:_____

Nasal sprays used in the past:_____Eyedrops used in the past:_____

Current environment:

Age of home: _____ Number of rooms: _____ Time at current residence:_____

Animals	❑ YES	❑ NO
Outdoor cat now	❑	
Indoor cat now	❑	
Indoor cat in the past	❑	
Outdoor dog now	❑	
Indoor dog now	❑	
Indoor dog in the past	❑	
Birds now or in past	❑	
Other animals	❑	

Household	❑ YES	❑ NO
Forced air heat	❑	
Rural living area	❑	
Swamp cooler	❑	
Smoking exposure	❑	

Humidity Problems	❑ YES	❑ NO
Moisture water damage	❑	
Mold growth	❑	

Other Triggers	❑ YES	❑ NO
Time in daycare	❑	
Animals in daycare	❑	
Latex/rubber exposure	❑	

Is there anything in your home or at work that triggers your allergies or asthma?_____

_____

_____

Previous residences:

City, State	from:	to:	City, State	from:	to:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Past Allergy and Asthma History :

	YES	NO
Have you had previous allergy testing?	❑	❑

If you answered yes, then please answer the following questions:

	YES	NO		YES	NO
Previous allergy shots?	❑	❑	Still on allergy shots?	❑	❑
Allergy shots have helped?	❑	❑	Frequency of allergy shots _____		
Any minor reactions?	❑	❑	Previous chest x-ray?	❑	❑

If you have had any major reactions, please describe? _____

Past Medical History:

Chronic Health Conditions

- ❑ High blood presure
- ❑ Heart disease
- ❑ Thyroid
- ❑ Diabetes
- ❑ Other:_____

_____

_____

Surgery:

- ❑ Appendectomy
- ❑ C-Section
- ❑ Hysterectomy
- ❑ Ear tubes
- ❑ Sinus
- ❑ Tonsils
- ❑ Adenoids
- ❑ Gallbladder

❑ Other:_____

_____

_____

Recent emergency visits last two years:_____

_____

Immunization Adverse Reactions **❑ Yes ❑ No**

Influenza shot this year ❑ Yes ❑ No When:_____ **Prevnar shot ❑ Yes ❑ No When:**_____

Pneumonia shot ❑ Yes ❑ No When:_____ **Are immunizations up to date ❑ Yes ❑ No When:**_____

Drug Allergies

Drug		*Symptom*	*Drug*		*Symptom*
_____	caused	_____	_____	caused	_____
_____	caused	_____	_____	caused	_____

FAMILY HISTORY:

	Nasal Allergies	Asthma	Food Allergies	Eczema	Emphysema	Hives
Father:	❑	❑	❑	❑	❑	❑
Mother	❑	❑	❑	❑	❑	❑
Brother(s):	❑	❑	❑	❑	❑	❑
Sister(s)	❑	❑	❑	❑	❑	❑
Children	❑	❑	❑	❑	❑	❑
Extended Family	❑	❑	❑	❑	❑	❑

Family history of severe infections, unexplained deaths, cystic fibrosis, lupus, thyroid disease, celiac/gluten or rheumatoid arthritis? ❑ YES ❑ NO

SOCIAL HISTORY:

Primary residence is: ❑ one home
❑ split between homes

Number of individuals in the household: _____

Current occupation/grade level (if student): _____

Preschool or Daycare: Yes ❑ No ❑

School/work loss from asthma/nasal symptoms: Yes ❑ No ❑

Do you have medical insurance: Yes ❑ No ❑

Other relevant social factors: _____

What are your hobbies and interests outside of work, school and family?

_____

Habits:	**YES**	**NO**
Alcohol consumption	❑	❑_____ drinks per week
Smoking currently	❑	❑ For _____ years ___ ppd
Smoking in past	❑	❑ For _____ years ___ ppd
Electronic Cigarettes (Vaping)	❑	❑
Marijuana use	❑	❑

REVIEW OF SYSTEMS: (check all that apply to you)

General
- ❑ Fatigue/localized weakness
- ❑ Fever/chills
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Unexplained weight loss
- ❑ Weight gain

SKIN
- ❑ Rash
- ❑ Wounds or Sores
- ❑ Swelling of the lips/face

SleepApnea
- ❑ Loud snoring
- ❑ Interrupted breathing during sleep
- ❑ Using CPAP

Cardiac
- ❑ Chest pain
- ❑ Palpitations
- ❑ Leg swelling
- ❑ Other heart condition:_____

GI
- ❑ Food getting stuck in throat
- ❑ Heartburn/reflux
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Diarrhea/constipation
- ❑ Liver disease

GU
- ❑ Painful urination
- ❑ Blood in the urine

Hematologic
- ❑ Swollen lymph nodes
- ❑ Anemia

Endocrine
- ❑ Hot intolerance
- ❑ Cold intolerance
- ❑ Diabetes/Pre-Diabetes
- ❑ Thyroid Problems

Neuro
- ❑ Memory problems
- ❑ Headache
- ❑ Numbness
- ❑ Dizziness/Vertigo
- ❑ Problems with balance

Musculo/skeletal
- ❑ Joint pain/muscle pain
- ❑ Joint swelling

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Other psychiatric condition

Physician Notes:

Name of person filling out this history form (print):_____

Relationship to patient if not the patient: _____

Nasal, Allergy, and Asthma Medications:

Please mark all medications that you are currently or have previously taken.

Antibiotics	present	past
Amoxicillin	❑	❑
Augmentin	❑	❑
Avelox	❑	❑
Bactim/Septra	❑	❑
Biaxin	❑	❑
Ceclor	❑	❑
Ceftin	❑	❑
Doxycycline	❑	❑
E-mycin	❑	❑
Levaquin	❑	❑
Omnicef	❑	❑
Suprax	❑	❑
Vantin	❑	❑
Zithromax (Z-Pack)	❑	❑
Other:_____		

Antihistamine/Decongestant Combination	present	past
Allegra D	❑	❑
Claritin D	❑	❑
Rynatan	❑	❑
Zyrtec D	❑	❑

Antihistamines	present	past
Allegra /Alavert	❑	❑
Benadyrl	❑	❑
Claritin/Loratadine	❑	❑
Clarinex	❑	❑
Fexofenadine	❑	❑
Hydroxyzine	❑	❑
OTC	❑	❑
Periactin	❑	❑
Xyzal	❑	❑
Zyrtec /Allertec/Cetirizine	❑	❑
Other:_____		

Asthma Medication	present	past
Albuterol	❑	❑
Advair Diskus (100, 250, 500)	❑	❑
Advair HFA (45, 115, 230)	❑	❑
Alvesco (80, 160)	❑	❑
Asmanex (110, 220)	❑	❑
Atrovent HFA	❑	❑
Combivent	❑	❑
Dulera (100, 200)	❑	❑
Flovent Diskus (50, 100, 250)	❑	❑
Flovent HFA (44, 110, 220)	❑	❑
Foradil	❑	❑
Maxair	❑	❑
Nebulized Med_____	❑	❑
Pulmicort Flex (90, 180)	❑	❑
Pulmicort resp. (.25, .5, 1)	❑	❑
QVAR (40, 80)	❑	❑
Spiriva Handihaler	❑	❑
Symbicort (80, 160)	❑	❑
Theophylline	❑	❑
Ventolin/Proventil	❑	❑
Xopenex	❑	❑
Zyflo CR	❑	❑
Other _____		

Other	present	past
Epi-pen	❑	❑

Decongestants	present	past
Entex	❑	❑
Sudafed	❑	❑
Other:_____		

Eye Drops	present	past
Acular	❑	❑
Alomide	❑	❑
Alrex	❑	❑
Bepreve	❑	❑
Naphcon A	❑	❑
Optivar	❑	❑
Pataday	❑	❑
Zaditor	❑	❑
Other:_____		

Nasal Sprays	present	past
Astelin	❑	❑
Astepro 0.15%	❑	❑
Atrovent nasal spray	❑	❑
Beconase	❑	❑
Cromolyn nasal spray	❑	❑
Flonase (fluticasone proprionate)	❑	❑
Ipratropium bromide	❑	❑
Nasacort	❑	❑
Nasarel	❑	❑
Nasonex	❑	❑
Omnaris	❑	❑
OTC nasal spray	❑	❑
Rhinocort	❑	❑
Vancenase	❑	❑
Other: _____		

Heartburn Medication	present	past
Aciphex	❑	❑
Antacids (OTC)	❑	❑
Axid	❑	❑
Nexium	❑	❑
Prevacid	❑	❑
Prilosec	❑	❑
Protonix	❑	❑
Tagamet	❑	❑
Zantac	❑	❑
Other:_____		

Complications of Medications	present	past
Aspirin allergy	❑	❑
Fatigue	❑	❑
Hearing loss	❑	❑
Nasal polyps	❑	❑
Nasal septal perforation	❑	❑
Singing problems	❑	❑
Sleep apnea	❑	❑
Speech problems	❑	❑
Other:_____		

_____

Physical Exam *(to be completed by clinician)*

Drug Allergies: _____

Vitals:

Pulse _____ Resp. _____ BP ___/___ Temp. _____ Wt. _____ Ht. _____

Eyes: _____ Heart: _____

Ears: _____ Abd: _____

Nose: _____ Ext: _____

Throat: _____ Neuro: _____

Lungs: _____ Skin: _____

Assessment:

_____

_____

_____

Plan:

_____

_____

_____

ASTHMA QUESTIONAIRE

Fill this out only if you have or suspect you have asthma.

What would you like to learn, change or accomplish during this visit with regard to your asthma? _____

_____

_____

Symptoms / Current Control

Age of Onset:_____ Age of Diagnosis:_____

Asthma Symptoms (check all that apply):

❑ Cough ❑ Wheezing ❑ Shortness of breath ❑ Chest tightness

❑ Frequent sputum (phlegm) production ❑ Other:_____

How many **days** in the past week have you had chest tightness, cough, shortness of breath, or wheezing (whistling in your chest)? _____

How many **nights** in the past week have you had chest tightness, cough, shortness of breath, or wheezing (whistling in your chest)?_____

How many days in the past week has asthma restricted your physical activity? _____

How many of your quick-relief inhalers (albuterol, Brethaire, Maxair, Proventil, Ventolin) did you go through over the past month?_____

Is your asthma becoming worse over time? ❑ Yes ❑ No

History of early life injury to airways

Premature birth (<36 weeks) ❑ Yes ❑ No Parental smoking ❑ Yes ❑ No

Pneumonia/bronchiolitis ❑ Yes ❑ No Home use oxygen ❑ Yes ❑ No

Pattern of Symptoms

Is your asthma present all year? ❑ Yes ❑ No

What months of the year is it worse?_____

How often do you have asthma episodes/attacks (this includes taking medication and/or altering activity level): _____ *times per year* _____ *times per month*

_____ *times per season (summer, fall, spring, winter)*

Do you have any of these symptoms at night or when you awake in the morning?

❑ cough ❑ wheezing ❑ chest tightness ❑ shortness of breath

❑ sputum production ❑ other:_____

Precipitating / Aggravating Factors

What makes your asthma worse? What are you exposed to? (Please check all that apply.)

❑ Colds	❑ Allergens	❑ Night time	❑ Cold air	❑ Pollution	❑ Stress/emotions
❑ Smoke	❑ Exercise	❑ Workplace	❑ School	❑ Sinusitis	❑ Reflux
❑ Cats	❑ Dogs	❑ Other animals:_____		❑ Dust	❑ Perfumes/odors
❑ Drugs *(aspirin, Motrin, Tylenol, beta-blockers)*				❑ Incense	❑ Weather changes
❑ Endocrine factors *(menses, pregnancy, thyroid disease)*				❑ Living near major roads	
❑ Fresh paint/linoleum		❑ Renovations/painting		❑ Bleach/cleaning products	
❑ Chlorinated pools		❑ Other:_____			

Do your asthma symptoms improve when on vacation for longer than a week? ❑ Yes ❑ No

(continue in next column)

Asthma Attacks/Exacerbations

Please list the approximate date and length of every hospitalization for asthma, bronchitis or pneumonia:_____

_____

_____

_____

Describe a typical asthma attack including any warning signs, the usual pattern, and the management (what works):_____

_____

_____

_____

How many emergency room visits for asthma have you made in the past year?_____

How many courses of **prednisone** have you received in the past year? _____

Have you had any life-threatening attacks (intensive care admissions, loss of consciousness, breathing machine, turning blue)? ❑ Yes ❑ No

What are your worries or concerns about asthma or asthma medications?

_____

_____

_____

Impact of Asthma on Patient and Family

Have you experienced any side-effects from your asthma medications? ❑ Yes ❑ No

Describe: _____

_____

_____

How many days of work/school have you missed in the past year due to asthma? ___

Is your activity limited by asthma (esp. sports, strenuous work) ❑ Yes ❑ No

Comments:_____

_____

_____

Does the cost of asthma medications make it difficult to buy them? ❑ Yes ❑ No

Has your asthma affected your school/work performance, lifestyle, behavior, family routines, etc? ❑ Yes ❑ No

Comments:_____

_____

Are there any other factors that affect your ability to take your asthma medication/follow your asthma treatment plan?_____

_____

_____

Are there other people who help you with your asthma management and/or function as a support system? ❑ Yes ❑ No

Please circle all that apply: spouse, significant other, father, mother, other relative, friend, other:_____

TO AVOID DELAYS IN TIME PLEASE COMPLETE THIS FORM IN FULL

BOISE VALLEY ASTHMA & ALLERGY CLINIC

PHONE (208) 378-0080

PLEASE PRINT

PATIENT NAME: _____
LAST FIRST MIDDLE SUFFIX

S.S #: _____ - _____ - _____ **DATE OF BIRTH:** _____/_____/_____ **GENDER:** _____ **NICKNAME:** _____
MM DD YYYY

ADDRESS: _____ **CITY, ST:** _____ **ZIP:** _____

PH. #:(_____ **)** _____-_____ **CELL #: (** _____ **)** _____ - _____ **ALT. #: (** _____ **)** _____- _____

RACE: _____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:** _____

PRIMARY PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

EMERGENCY CONTACT: _____ **PH. #: (** _____ **)** _____ - _____ **RELATIONSHIP:** _____

PREFERRED METHOD OF CONTACT FOR REMINDER CALLS AND OTHER ELECTRONICALLY GENERATED MESSAGES.

(PLEASE SELECT ONLY ONE OPTION) ❑ **TEXT** ❑ **VOICE (IF VOICE, PLEASE SELECT PREFERRED NUMBER.)** ❑ **HOME** ❑ **CELL** ❑ **WORK**

EMAIL: _____

SPOUSE

NAME: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
MM DD YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

EMPLOYER: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

PARENTS OR GUARDIANS (if minor)

FATHER: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
MM DD YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

EMPLOYER: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

MOTHER: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
MM DD YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

EMPLOYER: _____ **PH. #: (** _____ **)** _____ - _____

INSURANCE: _____ **POLICY #:** _____

RESPONSIBLE PARTY

PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

NAME: _____ **DATE OF BIRTH:** _____/_____/_____ **S.S. #:** _____-_____-_____
MM DD YYYY

ADDRESS: _____ **PH. #: (** _____ **)** _____ - _____

RELATIONSHIP TO PATIENT: _____ **PAYMENT METHOD:** _____

SIGNATURE OF RESPONSIBLE PARTY: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims theron, all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

Notice: Do not sign this agreement before you read and agree to the conditions set. You are entitled to a copy of this agreement at the time you sign if you wish.

FORM NO. 090889

Signature _____ Date _____
Parent or guardian if minor

John D. Jeppson M.D., Michael V. Keiley, M.D., G. William Palmer, M.D., Heidi Peters, FNP., Jennifer Neumayer, NP-C

ADULT AND CHILDHOOD
ASTHMA AND ALLERGY

PHYSICIANS ARE ALL BOARD CERTIFIED BY
THE AMERICAN BOARD
OF ALLERGY AND IMMUNOLOGY

Boise Valley
Asthma & Allergy
Clinic

901 N. CURTIS ROAD, SUITE 100
BOISE, IDAHO 83706
(208) 378-0080

2320 E GALA, SUITE 500
MERIDIAN, IDAHO 83642

SATELLITE CLINICS IN EAGLE, NAMPA AND CALDWELL

Patient Financial Policy

Boise Valley Asthma and Allergy Clinic aims to provide the very highest quality of care in a patient-centered environment. Compliance with this financial policy will help us reach this goal. Please take the time to read this document and call us with any questions. This document describes our financial policies, additional information on prescription refill limitations, as well as the importance of having a responsible adult available to accompany minor patients.

Insurance

- You are responsible for understanding the benefits and services provided by your health care plan. Listed below are some important things to know:
- You are responsible for all of our charges regardless of the type of insurance you have
- It is important to realize that your insurance plan is a contract between you and your insurance company (not the clinician).
- You should know if pre-authorization is required for specific procedures or specialty referral.

We will submit your claim to your insurance company. Our office does require 20% or your co-pay at the time of service. We allow 60 days for your insurance carrier to process & pay the claim. After that time the unpaid balance is due and will need to be paid by you. Our office never guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to verify your policy benefits and share that information with you. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.

Payments Accepted For your convenience, we accept cash, Master Card, Visa, as well as personal checks. Unless specifically requested, all payments are applied to the oldest invoices first. Patients can request payment on a specific invoice.

Collection Procedures Once an account is placed in collection status all future services must be paid in full at the time of service.

Prescription refill policy If you have not been seen in one year, we feel that it is important for the quality of your care to be seen before receiving prescription refills. In certain cases, we will provide a month supply of medication to tide you over until you are seen.

Addresses and Insurance Changes Please keep us informed of address, telephone number, or insurance changes. It is your responsibility to notify Boise Valley Asthma and Allergy Clinic within 30 days of insurance termination, Failure to comply will make you responsible for all charges incurred.

Returned Checks

A $20.00 dollar fee will be assessed on all returned checks.

Minor Patients

We require that a minor patient be accompanied by an adult (parent or legal guardian). The adult accompanying the minor patient is required to pay in accordance with our policies.
In case of family problems with divorce, etc., the parent or person who brings a minor patient into the office is directly responsible for the account. Our office will not be involved in family disputes.

I have read and understand the above Office Financial Policy and understand that I am ultimately responsible for charges incurred.

Patient Name: _____

_____ _____

Patient, Parent or Guardian Signature ***Date***

Boise Valley
Asthma & Allergy
Clinic

Discrimination is Against the Law

Boise Valley Asthma & Allergy Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Boise Valley Asthma & Allergy Clinic** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Boise Valley Asthma & Allergy Clinic:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Compliance Coordinator.

If you believe that **Boise Valley Valley Asthma & Allergy Clinic** has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Coordinator:	Chance Fuerstinger
Phone Number:	(208) 378-0080
Fax:	(208) 378-0259
Address:	901 N. Curtis Rd, Ste. 100 Boise, ID 83706

You can file a grievance in person, by mail, by fax, or by telephone. If you need help filing a grievance, the Civil Rights Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Boise Valley Asthma & Allergy Clinic no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Boise Valley
Asthma & Allergy
Clinic

Boise Valley Asthma & Allergy Clinic lehnt den Ausschluss oder die unterschiedliche Behandlung von Menschen aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-696-6775.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-696-6775.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-696-6775.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-696-6775。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-696-6775.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-696-6775.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-696-6775 まで、お電話にてご連絡ください。

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-696-6775.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-696-6775.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-696-6775.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-696-6775.

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-877-696-6775.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-696-6775 تماس بگیرید.