Accredited Asthma, Allergy, & Food Intolerance Center • 1009B Dupont Square North • Louisville, KY • 40207 • Phone (502)895-3330 • Fax (502)895-3356

IMPORTANT LIST OF MEDICATIONS TO AVOID - REVIEW IMMEDIATELY

ANTIHISTAMINES

****STOP 10 days PRIOR TO TESTING****

GENERIC NAME	BRAND NAME
Azelastine	Astelin
Azelastine	Optivar
Cetirizine	Zyrtec
Chlorcyclizine HCl	Ahist
Chlorcyclizine HCl	Stahist
Chlorpheniramine	Aller-Chlor
Chlorpheniramine	Chlo-Amine
Chlorpheniramine	Chlorphen
Chlorpheniramine	Chlor-Trimeton
Chlorpheniramine	C.P.M.
Chlorpheniramine	Effidac-24
Chlorpheniramine	Ridraman
Cimetidine	Tagamet
Clemastine	Allerhist-1
Clemastine	Contac 12 Hour Allergy
Clemastine	Tavist-1
Cyproheptadine	Periactin
Desloratidine	Clarinex
Diphenhydramine	Compoz Nighttime Sleep Aid
Diphenhydramine	Actifed Sinus Day
Diphenhydramine	Aler-Dryl
Diphenhydramine	Banophen
Diphenhydramine	Benadryl
Diphenhydramine	Calm-Aid
Diphenhydramine	Diphedryl
Diphenhydramine	Diphen
Diphenhydramine	Genahist
Diphenhydramine	Hydramine
Diphenhydramine	Nu-Med
Diphenhydramine	Nytol Caplet
Diphenhydramine	Sominex
Diphenhydramine	Twilite
Diphenhydramine	Tylenol PM
Diphenhydramine	Unisom Sleep gels
Doxepin	Adapin
Doxepin	Sinequan
Doxepin	Zonalon
Ebastine	Zonalon
Fexofenadine	Allegra
Hydroxyzine	Atarax
Hydroxyzine	Rezine
Hydroxyzine	Vistaril
Imipramines	Tofranil
Ketotifen	Zantac
Levocetirizine dihydrochloride	Xyzal
Loratidine	Alavert
Loratidine	Claritin
Mequitazine	Quintadrill
Phenothiazines	Chlorpromazine
Phenothiazines	Thorazine
Promethazine	Phenergan
Promethazine	Prorex
Ranitidine	Zantac
Tripelennamine	PBZ & PBZ-SR
Famotidine	Pepcid
Dymista	Fluticasone / Azelastine

ANTIHISTAMINES (CONT.)

****STOP 2 DAYS or 48 Hours PRIOR TO TESTING****

GENERIC NAME	BRAND NAME
Acrivastine	Semprex-D
Olopatadine	Pataday

Medications for Dizziness/Motion Sickness

****STOP 10 DAYS PRIOR TO TESTING****

GENERIC NAME	BRAND NAME
Meclizine Hydrochloride	Antivert
Meclizine	Dramamine

BETA BLOCKERS

****DO NOT TAKE these medications the MORNING OF your appointment****

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

HERBS

****STOP 7 DAYS PRIOR TO TESTING****

Licorice	
Green Tea	
Saw Palmetto	
St. John's Wort	
Feverfew	
Milk Thistle	
Astragalus	

TRICYCLIC ANTIDEPRESSANTS

****STOP 10 days PRIOR TO TESTING****

****Please contact the ordering physician before stopping these medications.****

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

PATIENT INFORMATION

(Please Print)

THIS SECTION IS PERTAINING TO THE PATIENT

NAME _____ SEX_____ BIRTHDATE _____/_____/_____ AGE _____
(Last) (First) (Middle)

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

Email:_____

SOCIAL SECURITY NUMBER _____-_____-_____ EMPLOYER/OCCUPATION _____

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

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

PERSON RESPONSIBLE FOR BILL (If not patient)

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

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

SOCIAL SECURITY NUMBER _____-_____-_____ EMPLOYER _____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY _____

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

ID NUMBER _____ GROUP NUMBER _____

EFFECTIVE DATE _____ RELATIONSHIP OF PATIENT TO SUBSCRIBER _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY _____

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

ID NUMBER _____ GROUP NUMBER _____

EFFECTIVE DATE _____ RELATIONSHIP OF PATIENT TO SUBSCRIBER _____

FAMILY PHYSICIAN AND REFERRAL INFORMATION

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

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

NAME OF REFERRING PHYSICIAN _____ PHONE ( ) _____ - _____

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

_____

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

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

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

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

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

06/2021 VF

C. STEVEN SMITH, MD
1009B Dupont Square North / Louisville, KY 40207 / (502) 895-3330
721 West 13th Street, Ste 225 / Jasper, IN 47546 Toll-Free: (844) 528-3330
www.drsmithallergy.com

Welcome! I am pleased you have chosen my practice to provide your asthma, allergy and food intolerance care. As a Board Certified Pediatrician, Adult & Pediatric Allergist and Immunologist, my focus is to provide patients with the highest quality, comprehensive, and patient prioritized care. I will act in a specialty consulting role with your referring or Primary Care Physician to provide you the best care. Please take a few moments to familiarize yourself with our office policies, complete the questionnaire, and sign our agreement for care. Thank you for choosing our office. My staff and I look forward to meeting you.

C. Steven Smith, MD

APPOINTMENTS:

Our patients' care is of the utmost importance. We see patients by appointment only and schedule only a very few (8 – 14) patients per day. For this reason, my staff and I would appreciate Louisville patients to give at least a 48 hour notice of cancellation or rescheduling and Jasper patients to give at least a one week notice of cancellation or rescheduling due to traveling twice a month . Without this notice, you will be charged a $100.00 late cancellation/no-show fee for changing the appointment. Patients who frequently miss appointments may be discharged from our practice. We value all our patients and appreciate your help in allowing us to provide the best quality of care.

INSURANCE:

Our office accepts all major insurance carriers and most of the smaller insurance companies. It is your responsibility to verify with your insurance company that we are within your network of providers. It is important for you to be aware of any co-payments, deductibles, fees, and limitations of services regarding your personal insurance policy. Copayments will be due at the time of your appointment and the remainder of your bill will be due upon receipt once all insurance adjustments and deductions have been processed. Please assist our staff in filing claims by bringing your insurance card to all office visits as well as new cards yearly. If your insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician before each appointment. Please be sure to inform our staff of any changes in insurance coverage, address, employment, telephone numbers, etc. during the year.

****Some insurance companies/policies have limitations on the amount of allergy testing. If you are interested in this route of care/treatment, we recommend checking with your insurance eligibility beforehand – the frequently used and restricted CPT code for "Pricks" is 95004 per item tested.**

PAYMENTS/RETURNED CHECKS

Payments for services not covered by your insurance will be due once all adjustments and payments have been processed following your appointment or service provided. There is a $35.00 charge for all returned checks. If you are not insured and wish to self-pay, payment will be due at the end of your appointment. All medical and school documents needing to be completed outside of an appointment will be charged a $25.00 administration fee.

MINOR CHILDREN:

A parent / legal guardian must accompany any patient under the age of 18 to all office visits. Before treating a child brought in by someone other than the parent / legal guardian, we require a signed "permission to treat" form. All HIPAA rules apply to minor children as well as adults. Patient care will only be discussed with authorized individuals.

Child's name: _____ Date: _____

I authorize treatment to be given to my child in the event of my absence.
Name of person authorized to accompany my child: _____

Parent / guardian signature: _____

I have read and understand the policies of Accredited Asthma, Allergy & Food Intolerance Center.

_____ Date: _____
Patient / Parent / Guardian Signature

Again, thank you for choosing our practice. I want to assure you that I will provide the best care possible with your best interest in mind at all times. I look forward to caring for you. ***C. Steven Smith, M***

ALLERGY TREATMENT CONSENT AND GENERAL INFORMATION

- ❖ Skin tests are a method of testing for allergic antibodies. A small amount of the allergen is introduced onto the skin. Results are read 15-20 minutes after the application of the test. A positive reaction consists of a wheal (hive or whelp) in the area at the test site. The skin test methods used are:

1. **PUDDLE METHOD**: A small amount of allergen is placed on the skin (in a puddle form) and results are read 15-20 minutes. A positive reaction consists of erythema and/or wheal (redness or hives).
2. **DERMAPICK METHOD:** A sterile plastic device with several small points covered with the allergen is gently scratched on the surface of your skin.
3. **INTERDERMAL METHOD:** A small amount of allergen is injected into the surface of the skin. Several of these tests may need to be done on the upper arm after the Dermapick Method.
4. **PATCH METHOD:** Used to determine contact skin reactions. This can be standard or customized designed test for items that you come in contact with (i.e. chemicals, make-up, detergent, soaps, hair products, and lotion). Test items are placed on your back and are checked each day for 4 consecutive days.

- ❖ You will be skin tested to airborne allergens and/or foods according to patient history. Airborne allergens include trees, grasses, weeds, molds, dust mites, and animal dander. **Testing generally takes between 2 to 4 hours.**

- ❖ Skin testing will be administered under Dr. Smith's direct guidance; occasionally reactions may require medical intervention. Very strong responses require the remainder of the test to be administered at another visit. These reactions may consist of any or all of the following symptoms: Itchy eyes, nose, throat, nasal congestion, runny nose, tightness in throat or chest, wheezing, light headedness, hives, and/or generalized itching. **SEVERE** reactions rarely occur; in the event of a reaction, the staff is fully trained and medically equipped to handle allergic emergencies.

- ❖ Most positive reactions from testing will gradually disappear over 30-60 minutes. Occasionally delayed swelling at a test site will occur 4 to 8 hours after skin testing. These reactions are not serious and will resolve over the next week or so.

- ❖ You may be scheduled for skin testing to certain antibiotics, local anesthesia ("caines"), insect venoms, or other biological agents. The same guidelines apply for inhalant and food testing.

- ❖ If you are being treated for hives, please alert our office. Your first visit may be a consult without skin testing if your hives are not under control at the time of service.

- ❖ Skin testing must be postponed if you or your child are experiencing fever above 101°F, influenza, vomiting, diarrhea, wheezing, new hives, sunburn/overly sun-exposed skin, or significant eczema.

- ❖ We are allotting 2-4 hours for your evaluation, including history, physical exam, testing, education, and planning your treatment. If we are unable to finish testing, some of these plans will be at subsequent test visits. If needing to change your skin test appointment, we ask for a 48-hour notice, otherwise you will be charged a fee for the missed appointment.

There is a **"List of Medications to Avoid"** available online at www.drsmithallergy.com under the "appointments" section. Guidelines when using this list include:

1. **DO NOT** use prescription or over-the-counter antihistamines 10 days prior to skin testing. These include some cold tablets, sinus tablets, hay fever medications, or oral medications for itchy skin (i.e. Atarax (hydroxyzine), Benadryl, Dimetapp, Triaminic, Claritin, Allegra, Zyrtec, Chlor-Trimeton, Xyzal, Alavert).
2. **DO NOT** stop taking the following medications that can affect your allergy testing without checking with your prescribing physician first: Tagament, Zantac, amytripyline (Elavil), doxepin (Sinequan), imipramine (Tofranil).
3. **DO NOT** stop taking "beta-blocker" medication used for high blood pressure, headaches, or glaucoma without first checking with the doctor who prescribed the medication. These medications typically only need to be held the morning of your appointment.
4. **YOU MAY** and should continue most allergy nasal sprays (i.e. Afrin, Nasacort AQ, Nasarel, Nasonex, and Rhinocort). **AVOID** Astelin (if unsure, please ask your pharmacist if your nasal spray contains an antihistamine if not listed).
5. **YOU MAY** and should use your asthma inhalers. These should be used as prescribed (i.e. Advair, Aerobid, Atrovent, Azmacort, Dulera, Foradil, Maxair, Proventil, Pulmicort, Quar, Serevent, Symbicort, Ventolin).
6. **YOU MAY** continue oral steroids such as Prednisone, except when being patch tested. You cannot receive patch testing until your system is totally clear of systemic steroids – usually 2 weeks after your last dose.
7. **YOU MAY** eat regularly on the day of testing and you should not skip any meals.

Should you have any questions regarding skin testing prior to your appointment, please call our office. Your Pharmacist can advise you if the medications you are taking are beta-blockers or antihistamines.

I have read and understand the information and authorize skin testing and/or medical treatment to be performed.

X_____

Patient/Legal Guardian Date

DATE:_____

Patient Name:_____ Date of Birth:_____

Patient Medication list

Do you have any drug allergies?: No / Yes (If yes, please list and specify reaction, ie: hives, rash, itching, asthma, shock, etc.)

Please list all prescription, Over-the-Counter, and supplements <u>taken in the past 6 months</u>:

Medication Name	Dosage/Route Frequency	Reason for use	Last taken

MD reviewed by:_____ Nurse Reviewed:_____

NEW PATIENT

Accredited Asthma, Allergy & Food Intolerance Center

C. Steven Smith, MD 1009B Dupont Square North, Louisville KY 40207 (502) 895-3330 Fax (502) 895-3356
West 13th Street, Ste 225, Jasper, IN 47546 Toll Free 844-528-3330

Name:_____AGE:_____DOB:_____ Heritage/Race: _____Date:_____
Primary Care Physician:_____ Referred by Physician/Other:_____
Other family members current/past patients:_____
Why do you want to see the doctor today? _____

Drug Allergy: ☐ No ☐ Yes (If yes, please list on medication sheet and specify form of reaction, ie: hives, rash, itching, asthma, shock, etc.)

Have you ever had allergy skin or blood testing? ☐ No ☐ Yes When? _____ Allergist ☐ ENT ☐ Other ☐:_____
Have you ever been on allergy shots/drops/pollen pills? ☐ No ☐ Yes How long? _____Response _____Reactions_____

General: Circle any factors that make you feel worse:
Animals House dust Musty odor Cold air Being indoors Being outdoors Being at work Smoke
Weather changes Dampness Raking leaves Lawn mowing Barns Foods
Do you have animals indoors? ☐No ☐Yes What type of animals? _____Do they sleep in your bedroom/bed: _____
Age of your home: _____ Damp areas: _____ Age of carpet :_____ Age of pillow :_____ Age of mattress:_____
Increased symptoms at work: ☐No ☐Yes Better out of this region of the country? ☐No ☐Yes

Eye Symptoms: Put a check mark by any eye symptoms that you experience:
☐ Itching ☐ Watering ☐ Redness ☐ Burning ☐ Dryness ☐ Loss of vision ☐ Eyelid swelling
☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ Off and on all year
Your Ophthalmologist (Eye) Doctor:_____

Nasal (nose)/ Sinus / Ear Symptoms:
Age when symptoms first started_____. Age when allergies were first diagnosed_____ Type _____
Put a check mark by nasal symptoms that you experience:
☐ Itching ☐ Stuffiness ☐ Runny nose ☐ Discolored Discharge ☐ Bleeding ☐ Loss of sense of smell ☐ Odor intolerance
Is sleep disturbed by nasal congestion? ☐ No ☐ Yes _____
Do you get sinus infections? ☐ No ☐ Yes How often? _____
Do you get ear infections? ☐ No ☐ Yes How often? _____
Have you had x-rays or CT scan of your sinuses? ☐ No ☐ Yes When? _____
Have you broken your nose or had sinus surgery? ☐ No ☐ Yes When?_____

Chest Symptoms:
Age when asthma/chest symptoms first started_____
Circle symptoms: *Shortness of breath Wheezing Cough Tight chest Infections Other*_____
Number of days per week you have chest symptoms: _____ Number of nights per week asthma disturbs sleep: _____
Have you ever:
Been treated in an emergency room for asthma? ☐ No ☐ Yes-when? _____
Been hospitalized for asthma? ☐ No ☐ Yes-when? _____
Had intensive care treatment for asthma? ☐ No ☐ Yes-when? _____
Been intubated? ☐ No ☐ Yes-when? _____
Taken steroid pills or shots for asthma? ☐ No ☐ Yes How many times per year?_____
Had an abnormal chest x-ray or C.T.? ☐ No ☐ Yes-when? _____
Your Pulmonologist (Lung) Doctor:_____

Pattern of Asthma:
Check which season(s) asthma symptoms are most frequent: ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ All year
What time of day asthma symptoms are most frequent: ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime
Causes:
Animals House dust Smoke Cold air Foods Exercise Infections Weather changes Air Pollution Hot/Humid weather
Work Place Exposures? (*List)*_____

Social History:
Do you or did you smoke tobacco? ☐No ☐Yes How many years did you or have you smoked? _____ Still?_____
How many alcoholic beverages do you have per week? _____ Per day? _____Type_____

Skin Allergy:
Eczema: _____ Hives/swelling: _____ Oozing:_____ Skin Rash:_____ Blistering Skin:_____

Food Allergy: Check symptoms that happen after you eat a food that you think causes problems:
☐ Itchy mouth ☐ Swollen throat ☐ Vomiting ☐ Diarrhea ☐ Asthma ☐ Head Congestion ☐ Anaphylactic Shock ☐ Hives
Which foods cause this: _____ Date of last reaction_____
Do you have trouble swallowing certain foods? ☐No ☐Yes Do you have gluten intolerance or IC? ☐No ☐Yes
Name of Gastroenterologist (stomach) Doctor:_____Last Seen_____
Biopsy ☐ Bloodwork ☐ Genetics for Gluten ☐

Latex allergy: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____
Stinging Insects: reactions ☐ No ☐ Yes Type of insect _____Symptoms _____Date last reaction_____

Please tell us if you currently have or had a past history of any of the following conditions.
If you answer yes, please circle condition and give dates that the condition started, stopped or if it is continuing.

			Describe
Head/Ears/Eyes:	Problems with your eyes, ears or throat?	☐ No ☐ Yes	_____
Nose/Throat:	Speech or hearing problems?	☐No ☐ Yes	_____
	Headaches (cluster, tension, migraines) or seizures?	☐ No ☐ Yes	_____
	Sinus problems (loss of smell, polyps, infection)?	☐ No ☐ Yes	_____
	Mouth/throat problems (infections, hoarseness, dental)	☐ No ☐Yes	_____
	Problems with vision?	☐ No ☐ Yes	_____
Emotional:	Do you feel nervous, angry, suicidal, depressed, lonely, sad, out of control, or have phobias?	☐ No ☐ Yes	_____
	Do you have trouble sleeping?	☐ No ☐ Yes	_____
Endocrine:	Diagnosed with diabetes?	☐ No ☐ Yes	When?_____Type:_____
	Do you have thyroid disease?	☐ No ☐ Yes	_____
	Cataracts?	☐ No ☐ Yes	_____
Circulatory:	Heart problems (high blood pressure, palpitations, chest pain, irregular heart beat)?	☐ No ☐ Yes	_____
Respiratory:	Lung problems (bronchitis, pneumonia, TB, emphysema)?	☐ No ☐ Yes	_____
Gastrointestinal:	Recent problems with eating, drinking, swallowing?	☐ No ☐ Yes	_____
	Problems with nausea, vomiting, abdominal pain, constant diarrhea or bloody stools?	☐ No ☐ Yes	_____
	Do you or 1st degree relatives have gluten intolerance?	☐ No ☐ Yes	_____
	Ulcers, hernias, indigestion, cirrhosis, or hepatitis?	☐ No ☐ Yes	_____
Genital/Urinary:	Burning, pain or frequency when urinating?	☐ No ☐ Yes	_____
	Do you have interstitial cystitis?	☐ No ☐ Yes	_____
	Have you had kidney stones, prostate infection_ (male), or urinary tract (bladder) infections?	☐ No ☐ Yes	_____
	Do you have or had any type of STD?	☐ No ☐ Yes	Type _____
Immune:	Cancer, blood diseases, deficiencies, anemia?	☐ No ☐ Yes	_____
Mobility:	Muscular/joint (i.e. arthritis) bone/orthopedic problems or difficulty with coordination/balance?	☐ No ☐ Yes	_____
Skin:	Problems with your skin (rash, hives, changes in skin/hair, cold sores, eczema, contact dermatitis	☐ No ☐ Yes	_____
HIV:	Positive?	☐ No ☐ Yes	_____
Hepatitis:	A B or C	☐ No ☐ Yes	Which type _____When?_____

Date and type of surgery/hospitalizations:
_____
_____
_____
_____
_____

What illnesses "run" in your immediate family (parents, grandparents, siblings):
_____
_____
_____
_____