Allergy & Asthma Specialty Services, P. S.

T. Ted Song, D.O. Kristi McKinney, M.D. Jennifer Cole, D.O. Kelly Lundberg, ARNP

Office Addresses & Shot Hours

Lakewood Office: 11203 Bridgeport Way S.W.
Lakewood, WA 98499
Phone: (253)589-1380
Monday/Thursday 730am-1130am/1-6pm **Tuesday** 730am-1130am/1pm-430pm
Saturday 730am-1130am

Puyallup Office: 318 39th Ave S.W., Suite B
Puyallup, WA 98373
Phone: (253)589-1380
Monday/Thursday 730am-1130am/1-6pm **Tuesday** 730am-1130am/1pm-430pm

Gig Harbor Office: 4700 Point Fosdick Dr. NW, Suite 310
Gig Harbor, WA 98335
Phone: (253)589-1380
Monday/Thursday 730am-1130am/1pm-6pm **Tuesday** 730am-1130pm/1pm-430pm

Olympia Office: 3920 Capital Mall Drive SW, Suite 304
Olympia, WA 98502
Phone: (253)589-1380
*If you use GPS Capital must be spelled: CAPITOL MALL DRIVE
* Please feel free to utilize the free valet parking service located at the front entrance of Capital Medical Center, otherwise allow time for parking!
Monday, Tuesday and Thursday 830am-1230pm 130pm – 500pm

Silverdale Office: 9657 Levin Road, Suite 250
Silverdale, WA 98383
Phone: (253)589-1380
Wednesday 800am-430pm
Friday 730am-12pm

Allergy and Asthma Specialty Services, P.S.

T. Ted Song, D.O. Kristi McKinney, M.D. Jennifer Cole, D.O.
Kelly Lundberg, ARNP

Pulse: ________ Nurse: ________________________
Resp: ________ Wgt: ________________________
O2: __________ Last AH date: ________________
BP: __________ AH name: ____________________
CIU Score: _______________

ALLERGY WORKSHEET

NAME:	AGE:	BIRTHDATE:	DATE:
HOME ADDRESS:	PHONE:		

HISTORY: (for physician only)

Pulm Function Test: Yes No

1:_______
2:_______
3:_______
4:_______
5:_______

Total: ______

Have you ever been hospitalized or visited an Emergency Room for your symptoms? Yes No
When?

Do you notice any association between symptoms and any Foods, Medications, or anything you apply to your body? (If yes, please list)

CHECK YOUR MAIN SYMPTOMS BELOW:

☐ blocked nose	☐ bad breath	☐ red eyes	☐ skin rash	☐ chest pain
☐ itchy nose	☐ post nasal drip	☐ itchy eyes	☐ faintness	☐ palpitations (heart flutter)
☐ runny nose	☐ facial pain	☐ watery eyes	☐ unconsciousness	☐ diarrhea
☐ sneezing	☐ blocked ears	☐ headache	☐ shortness of breath	☐ stomach pain
☐ poor sense of smell	☐ itchy ears	☐ frequent colds	☐ wheezing	☐ stomach cramp
☐ discolored nasal mucus	☐ eczema	☐ swelling	☐ chronic cough	☐ others
	☐ itching	☐ hives	☐ night cough	
	☐ welts	☐ tightness of the chest		

When did symptoms first appear?

What time of year is worse?(Which months):

Check those factors below which cause or increase your symptoms:

☐Air conditioning	☐Dust, indoors	☐Flowers, trees	☐Paint, varnish	☐Tobacco smoke
☐Air pollution	☐Dust, outdoors	☐Grasses, weeds	☐Pets, other animals	☐Winds, drafts
☐Aspirin	☐Exertion	☐Industrial fumes	☐Pregnancy	☐Worry, tension
☐Bright lights	☐Fabrics	☐Insecticides	☐Rain, dampness	☐Sun
☐Colds, flu	☐Feathers	☐Menses	☐Soaps, detergents	☐Vibration
☐Cosmetics, perfumes	☐Fireplace smoke	☐Newsprint	☐Temperature change	☐Other
☐Heat				

ALLERGY WORKSHEET (Con't)

NAME:	AGE:	BIRTHDATE:	DATE:

Have you had allergy tests before?
□ YES □ NO **If yes, where was the testing done?**

Have you taken allergy shots?
□ YES □ NO **If yes, number of years? _____** **Year Stopped____**

Did Shots Help?
YES □ NO □

Do you have a food allergy? **□ YES □ NO** **If yes, which foods?**

Do you have a drug allergy? **□ YES □ NO** **If yes, which drugs?**

Do you have an allergy to insects? **□ YES □ NO** **If yes, which insects?**

Is there any family history of?

Allergies?	**□ Yes**	**□ No**	**Who?**
Asthma?	**□ Yes**	**□ No**	**Who?**
Eczema?	**□ Yes**	**□ No**	**Who?**

Do you have any of the following symptoms? (check any that apply)

□ Fever	**□ Problems with your skin**	**□ Problems with your blood**
□ Problems with your digestive system	**□ Problems with your bones or joints**	**□ Dental problems**
□ Problems with your urinary tract	**□ Problems with your heart**	**□ "Heartburn"**
□ Weight Loss	**□ Problems with your nervous system**	**□ Swollen lymph nodes or other masses**
□ Other:		

Check any diseases or surgeries you may have had:

□sinus surgery	**□tonsillectomy**	**□migraine**	**□tuberculosis**	**□hiatus hernia**	**□seizure/epilepsy**
□sinus infection	**□adenoidectomy**	**□kidney disease**	**□heart disease**	**□pneumonia**	**□bronchitis**
□polyp removal	**□ear surgery**	**□hypertension**	**□glaucoma**	**□liver disease**	**□hysterectomy**
□nose surgery	**□arthritis**	**□cancer**	**□diabetes**	**□appendectomy**	

List any other medical diagnosis or surgeries:

How long have you lived in Washington State? ___________________________________

Where did you grow up? __________________________Where did you live before Washington State? ____________________

Do you smoke? **□ Yes □ No**
If yes, how much? ___________
If you have quit smoking,
How many years did you smoke?
Do others smoke at home? **□ Yes □ No**
When did you quit?

Do you have pets? **□ Yes □ No**
Are they indoor or outdoor pets?
List type of pets:

Where do pets sleep? ________________________

What is your occupation?

Work location? **Indoors** **Outdoors**

Home Location

□Rural	**□Near Freeway**
□Suburbs	**□Near Farming**
□Near Industry	**□Urban**

Home Heating System:

□Gas	**□Electric**	**□In wall heaters**
□Baseboard	**□Forced Air**	
□Radiant Heat	**□Woodstove**	
□Fireplace	**□Heat Pump**	
□Oil	**□Radiant**	

Bedroom

□Carpeting	**□Indoor plants**
□Feather bedding	

Mattress Type

□Innerspring	**□Foam**
□Waterbed	**□Futon**

Allergy & Asthma Specialty Service, P.S.

T. Ted Song, D.O. Kristi McKinney, M.D. Jennifer Cole, D.O. Kelly Lundberg, ARNP

Current List Of Medications

Name: ______________________________________ **Birthday:** ____________

Pharmacy: _______________

Please note that it is important for the Allergist to know your current medications you are taking and the date you started to take them. This way the Allergist can check if there are any drug interactions.

#	Name of Medication	Strength	How Often Taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

ALLERGY AND ASTHMA SPECIALTY SERVICE, P.S.

Common Medications to Avoid Prior to Testing

Patients please note: Antihistamines and other medications can affect how patients respond to allergy testing. The medications that affect skin testing are antihistamines, some antidepressant and GI medications called H2 blockers. You should not stop any other medication(s) you are taking that have been prescribed by your doctor(s). It is impossible to have a complete list of antihistamines, so always review your medications to see if they contain antihistamines. Herbal medications may contain antihistamines as well.

Here is a list of common medications that can affect response to skin testing:

1. Prescription Antihistamines – ***DO NOT TAKE 72 HOURS PRIOR TO TESTING***					
Actidil (triprolidine)	Brocon	Dytuss	Historal	Nolamine	Rynatan
ADAC	Citra	Extendryl 4-Way cold	Hycomine	Optimine	Rynatuss
Albatussin	Co-Pyronil	tab Fedahist	Isoclor	PBZ	Seprex –D
Ambenyl	Codimal	Fedrazil	Kronofed –A	Periactin – (cyproheptadin)	Sinulin Tablets
Anamine	Comhist	Fiogesic	Kronofed –A Jr.	Phenergan-(promethazine)	Tacaryl
Atrohist Ped.	Comtrex	Disophrol	Meclizine	Protid	Tavist – (Clemestine)
Atrohist plus Tablets	Contac	Hispril	Naldecon	Quelidrine	Trinolin
Azatadine	Dextratussin	Histabid	Napril	Rhinex	Tussionex
Bomfed Capsules	Dura-Vent DA	Histadyl	Neotep	Rhondec	
Brexin	Duratap Pd	Histopan	Nolahist Tablets	Ru-Tuss	

2. Over the Counter Antihistamines – ***DO NOT TAKE 72 HOURS PRIOR TO TESTING***					
Actifed	Cerose DM	Dimetane	Ryna-12	Sominex	Triaminic
Alka-Seltzer Cold	Chlor-Trimeton	Dimetapp	Ryna-C	Sudafed Cold &	Triaminicol
Alka-Seltzer Flu	Chlorpheniramine	Dristan	Ryna-C Liquid	Allergy	Tussi-12
Alka-Seltzer Night	Comtrex Allergy–Sinus	Drixoral	S-T Forte	Sudafed Plus	Tylenol Allergy
Alka-Seltzer PLUS	Comtrex Cold & Flu	Excedrin PM Cough	Singlet	Tanafed	Tylenol Cold
Alka-Seltzer Sinus	Contact-Allergy	& Cold	Sinovan	Tavist D	Tylenol Flu
Aller-Chlor	Coridcidin Cough	Herbal Allergy Med.	Sine-Aid	Teldrin Allergy	Tylenol PM
Allerest	Coricidin D	Formula 44	Sine-Off Cold	Thera-Flu	Tylenol Sinus
BC Allergy	Coricidin Night-Time	Mescolor	Sine-Off Sinus	Thera-Flu Cold	Vicks Formula 44
Benadryl -	DA Chewables	Nyquil	SinuTab	Thera-Flu Sinus	***All Sleep Aides***
(Diphenhydramine)	Deconamine	Pedia-Care	Sinus Cold Powder		

3. Antihistamines – ***DO NOT TAKE 10 DAYS PRIOR TO TESTING***				
Allegra - (fexofenadine HCL)	Clarinex - (desloratadine)	Palgic – (carbinoxamine maleate)	Vistaril - (hydroxyzine)	Zyrtec - (cetirizine HCL)
Atarax - (hydroxyzine)	Claritin - (loratadine)	Seldane - (tertenadine)	Xyzal – (levocetirizine)	

4. Antihistamines – ***DO NOT TAKE 2 MONTHS PRIOR TO TESTING :*** Hismanal - (astemizole)

5. Nasal Sprays with Antihistamines – ***DO NOT TAKE 72 HOURS PRIOR TO TESTING***				
Astelin	Astepro	Azelastine	Dymista	Patanase

6. Eye Drops with Antihistamines – ***DO NOT TAKE 72 HOURS PRIOR TO TESTING*** ***Any over the counter allergy eye drops that may contain antihistamines.***				
Alvalon-A	Lastacaft (alcaftadine)	Pataday	Patanol	Vasacon-A
	Livostin		Systane	Zaditor

7. Eye Drops with Antihistamines – ***DO NOT TAKE 48 HOURS PRIOR TO TESTING:*** Optivar Eye drop-(azelastine)

8. Anti-Itch Creams with Antihistamines – ***DO NOT TAKE 24 HOURS PRIOR TO TESTING***			
Cortaid	Triamcinolone cream	Gold Bond	Lanacane

9. Muscle Relaxers – ***DO NOT TAKE 72 HOURS PRIOR TO TESTING***

Cyclobenzaprene – (Flexeril)

10. Antidepressants & Tranquilizers – ***IF POSSIBLE DO NOT TAKE 72 HOURS PRIOR TO TESTING*** ***Always ask your doctor prior to stopping any antidepressants or tranquilizers.***					
Abilify	Deprol	Ludiomil	Nisequan	Pertofrane	Surmontil
Acendir	Doxepin (Sinequam)	Lumbitrol	Norpramin	Remeron (Mirtazapine)	Tofranil
Adepin	Elavil	Nardil	Pamelor	Risperdal	Triavil
Amitriptyline	Endep	Marplan	Parnate	Seroquel	Vivactil
Arentyl	Etroafon				

11. Antidepressants & Tranquilizers – ***IF POSSIBLE DO NOT TAKE 10 DAYS PRIOR TO TESTING*** Antivert (Meclizine)

Always ask your doctor prior to stopping any antidepressants or tranquilizers.

12. H2 blockers (also sometimes referred to as acid reducers or H2 receptor antagonists) are available in nonprescription and prescription forms. IF POSSIBLE DO NOT TAKE 3 DAYS PRIOR TO TESTING Brand and generic name:					
Axid	Zantac	Pepcid	Tagamet		
Generic: nizatidine	Generic: Ranitidine	Generic: famotidine	Generic: cimetidine		

General Patient Information

Last Name ______ First Name ______ MI ______ Please circle one: **SEX: M F**

Mailing Address ______

City **State** **Zip** ______

Patients Age: ______ **Date of Birth:** ______ Month/ Day/ Year

Employer: ______

Race: **Please circle one**

Decline Caucasian African American Hispanic Asian

Native American Pacific Islander Other: ______

Ethnicity: **Please circle one**

Decline Hispanic or Latino Non- Hispanic or Latino Unknown

Best Daytime Phone #: (______) ______-______ Please circle one: (Mobile, Home or Work)

Check one: Self Spouse Parent Other: ______

Alternate Phone #: (______) ______-______ Please circle one: (Mobile, Home or Work)

Check one: Self Spouse Parent Other: ______

Email Address: ______

Emergency Contact:

______

Name Phone # Relation to Patient

---

1. **Do you have other family members who are seen by our providers? If so, list name(s) & their relationship to patient.**
   Please Circle one: No Yes : ______
2. **Were you referred to us by a healthcare provider?**
   Please Circle one: No Yes : ______
3. **Would you like you visit sent to your primary care provider? Please state title, such as: MD, ARNP, DO , ND**
   Please Circle one: No Yes : ______

Insurance Information

Primary Insurance Company Name: ______

ID/ Member #:______ Insurance Address: ______ Street City/ State Zip

Group or Local #: ______

Subscriber's Name: ______ (As it appears on insurance card) Employer of Subscriber: ______

Subscriber's Date of Birth: ______ Please Circle one: Subscriber's Relationship to patient: Self Spouse Other: ______

Secondary Insurance: NO YES: ______

ID/ Member #:______ Insurance Address: ______ Street City/ State Zip

Group or Local #: ______

Subscriber's Name: ______ (As it appears on insurance card) Employer of Subscriber: ______

Subscriber's Date of Birth: ______ Please Circle one: Subscriber's Relationship to patient: Self Spouse Other: ______

Assignment of Insurance Benefits/ Consent to Care

I authorize and request my insurance company to pay directly to the doctor the amount(s) billed on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover entire medical and surgical expense, I will be responsible for payment of the difference: and if the nature of the disability be such that it is not covered by the policy I will be responsible to the doctor for payment of the entire bill.

Patient or Guarantor's signature: ______ **Date**: ______

Print Name of Signature Above: ______ **Relationship to Patient**: Please Circle one: Self Parent/ Legal Guardian Other: ______

Paperwork for New Patients

Last Name:		First Name:		MI:		BD:	
Appt w/Allergist		Office					
Appt Date:		Appt Time:					
Name of Receptionist Preparing Paperwork:		Date Mailed:					

Date: July 23, 2019

Welcome to our office! Below you will find some information that will be helpful for you.

Be aware that we will not know if the doctor will be ordering any tests on your first visit. (Check the list of medications you need to avoid that is included in this packet). The doctor will make the decision after evaluating your medical problem. In case you are tested you need to be prepared with the following:

- Please wear a loose, short-sleeved shirt so the nurse can access your arms for testing.
- Testing appointments usually run about 2 ½ hours.

Please fill out the forms that are included in this packet and bring them to your first appointment.

- Please arrive 15 minutes prior to your appointment time so that the receptionist can go over the paperwork and get you checked in.
- Please refrain from using any fragrance or fragrant lotions as they can cause allergy or asthma symptoms to patients and staff. Do wear comfortable clothing.
- We recommend you do not bring small children to your testing appointment as it may be difficult for them due to the length of the testing process.
- Please bring all your medical insurance cards and photo ID to your first appointment.
- Copays are an agreement between you and your medical insurance and they need to be paid at the time of service. Please come prepared to pay this at your visit with us or there will be a $10 service fee added on to the copay amount.
- Provider One and HMO plan patients: You need to bring your Provider One and HMO card to the first office visit or allergy shot of each month.. Your Provider One card requires us to check your benefits on a monthly basis.

Allergy & Asthma Specialty Service, P.S.

CONSENT TO DISCUSS MEDICAL CARE

Patient Name: (please print) ___________________ Date of birth: _________________________

I authorize Allergy & Asthma Specialty Service (AASS) to discuss my medical information with the following individuals I have listed below. Please print all names. You do **NOT** need to list physicians.

Name	Date of birth	Relationship
Name	Date of birth	Relationship
Name	Date of birth	Relationship
Name	Date of birth	Relationship

I give my permission for AASS to leave detailed medical information at my telephone number(s):

☐ ( ) ______-_________ ( ) ______-_________

☐ Or, I do not want detailed medical information left on any of my phone numbers.

___________________________________ ____________________________
(Signature of patient, parent or legal guardian) Date

____
Printed name of signature above

CONSENT FOR TREATMENT OF A MINOR
Established patients ONLY

Date: _____________

I, ____________________________, the parent/legal guardian of ____________________________,
Please print your name **Please print patient's name**

_________________________ authorize and consent to routine and medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right of prior informed consent to such treatment. **This authorization shall remain effective unless revoked in writing by me.**

____
Signature of parent/guardian **Date signed**

- **NOTE: For your child's safety, AASS requires all children under the age of 16 to be accompanied by an adult (18years or older) for the duration of their visit when receiving allergy shots or being seen by the physician.**