Carl E. Thornblade, MD
Allergy, Asthma, and Immunology
2801 Great Northern Loop Suite 101, Missoula, MT 59808
Phone: (406)728-6472 Fax: (406)728-9175
www.drthornblade.com

Testing for Allergy or Asthma

Patient Name: ______________________________

Date of Appointment: ______________________________

Time of Appointment: ______________________________

If you need to cancel your appointment, please give us 48 hours notice. Thank you!

- **Check in 15 minutes early with ALL paperwork filled out.** Appointment may last **up to 3 hours**. Please complete the enclosed paperwork and bring with you to the appointment.
- **Benadryl** must be stopped **3** days early **prior** to appointment. **Antihistamines that need to be stopped for 7 days prior are Xyzal, Zyrtec, Claritin, Clarinex, and Allegra. If you have chronic hives, DO NOT stop Antihistamines.**

Topical Nasal steroid medications and asthma medications do not need to be stopped.
Eating before testing will not interfere.
We request that only the child scheduled for the appointment come as this will require your full attention.
Our office requires 20% of the charges on the day of service, your copay if you have met your deductible or $200 deposit if you have not met your deductible. We accept Visa, Master Card, Discover and American Express.

We are located at **2801 Great Northern Loop** (in the "W" Building); this is just off of Mullan Road between Broadway and Reserve Streets (near Missoula Bone & Joint and CostCare).

Directions to our office from the south side of Missoula:
Highway 93 enters Missoula as Brooks Street. Travel to the light at Reserve Street and turn left onto Reserve Street. Continue to the intersection of Mullan Road and Reserve Street and take a right onto Mullan Road. Travel past Great Northern *Avenue* and take the next left, onto Great Northern *Loop*. We are the very first building on the left of Great Northern Loop.

Directions to our Office from I-90:
Take the Reserve Street Exit, then turn south onto Reserve Street. Head south until you reach the light at the intersection of Mullan Road and Reserve Street. Turn left onto Mullan Road, heading east. Travel past Great Northern *Avenue* and take the next left, onto Great Northern *Loop*. We are the very first building on the left of Great Northern Loop.

List of Antihistamines to **STOP** taking before your appointment!
(If you have chronic hives, DO NOT stop antihistamines.)

Stop these antihistamines for *7 days* before your appointment:

Claritin, Alavert - *(Loratadine)*
Clarinex - *(Desloratadine)*
Actifed, Vistril – *(Hydroxyzine)*
Atarax, Vistaril – *(Hydroxyzine)*
Phenergan – *(Promethazine)*
Zyrtec – *(Cetirizine)*
Allegra - *(Fexofenadine)*
Xyzal – *(Levocetirizine)*
Actifed, Dim*etapp –(Brompheniramine)*
Chlortrimeton – *(Chlorpheniramine)*
Tavist, Antihist – *(Clemastine)*
Prochlorperazine *(Compazine)*
Actifed, Aller-Chlor, Bromfed, Drixoral,
Dura-Tab, Novafed-A, Ornade, Poly Histine-D, Trinalin *(Combination Medicines)*

Do not use: *Over the counter Cold or Allergy remedies,*
Over the counter and prescription cough syrups,
Or Quercitin, Nettle *(Herbal Medicine)*

Stop these Nasal Sprays: *Patanase - Astepro - Astelin*
Stop All Allergy Eye Drops

Stop these medications for *3 days* before your appointment:

Benadryl *(Diphenhydramine)*
Tylenol PM
Metoclopramide *(Reglan)*

Stop these medications the *Morning of* your appointment:

Tagamet - *(Cimetadine)*
Pepcid – *(Famotidine)*
Zantac – *(Ranitidine)*
Axid – *(Nizatidine)*

**Continue all Asthma Inhalers*
**Continue Singulair (Montelukast)*
**Continue Nasal Steroid Sprays (Flonase, Nasonex, Veramyst, etc.)*
**Continue all of your other usual medications*

Call us if you take any of the medications listed below as they ***may interfere*** with allergy testing. You should not stop them unless you talk with your primary doctor.

Amitriptyline (*Elavil, Vanatrip, Endep*)
Amoxapine
Clomipramine (*Anafranil*)
Doxepin (*Adapin, Sinequan*)
Desipramine (*Norpramin*)
Imipramine (*Tofranil)*
Nortriptyline (*Pamelor*)
Remeron (*Mirtazapine*)
Seroquel (*Quetiapine*)
Valium (*Diazepam*)
Zolpidem (*Ambien*)

REGISTRATION FORM

Dr. Carl E. Thornblade M.D.

(Please print)

Date_______________

Patient Information

Patient Name____ Male_____ Female _____ SSN___________________________

Mailing Address_______________________________________ Date of Birth _____/_____/_____ Married_____ Single______

City/State/Zip Code____________________________________ Age _____________ Email ______________________________

Business Phone #___________________ Home Phone #_____________________ Cell Phone # __________________________

Occupation _______________________ Employer _________________________ Primary Care Physician____________________

How did you hear about Dr Thornblade? ____

What Ethnic Group do you identify with? (Please note we identify with this for our Lung testing.)

☐ Asian ☐ African American ☐ Caucasian ☐ Native American ☐ Middle Eastern ☐ Other____________________

Mother's Name: __________________________________ Father's Name: _______________________________________
(If patient is a minor.)

Insured Information (if not patient) or Responsible Party for Payment

Insured's Name____ Relationship to Patient____________________________

Mailing Address____ Date of Birth _______________ SSN__________________

City/State/Zip Code ____ Home Phone # ___________________

Employer ____ Business Phone # _________________

Employer's Address____

Emergency Information

Emergency Contact: ____ Daytime Phone # ______________________________

Relationship to Patient____

Insurance Company Information

Primary Insurance Company ______________________________________ (Please Present Card for Photo Copying)

Primary Insured's Name ____

Policy # ___________________________ Group #___________________________

Secondary Insurance Company _____________________________________

Secondary Insured's Name ____

Policy # ___________________________ Group # ___________________________

Authorization to Release Information and Assignment of Insurance Benefits

I authorize the release of any medical information necessary to process medical claims. I permit a copy of this authorization to be used in the place of the original. I hereby authorize that payment from my insurance company be made directly to Dr Thornblade and I understand that I am financially responsible for charges not covered by my insurance company.

____ Date: _________________
(Signature of Patient, Policy Holder, or Parent)

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Board Certified in Allergy/Immunology
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Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: ~ Conduct, plan and direct my treatment and follow –up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. ~ Obtain payment from third-party payers. ~ Conduct normal healthcare operations such as quality assessments and physician certifications.

Consent for Use and Disclosure of Protected Health Information

With my consent, Carl Thornblade, MD may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). Please refer to Carl Thornblade's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Carl Thornblade reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the address above.

With my consent, Carl Thornblade may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent Carl Thornblade may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Carl Thornblade restrict how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Carl Thornblade's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Carl Thornblade, MD may decline to provide treatment to me.

Patient's Name (printed):________________________________**Date of Birth:**______________________

Signature of Patient or Legal Guardian:______________________________ **Date:** _________________

Printed Name of Legal Guardian:____

____________________________________Office Use Only_____________________________________

An attempt was made to obtain the patient's signature but unable to do so as documented below:

Date: ____________________ Initials: _______ Reason: ____

Dr. Thornblade' s Financial Policies
Effective February 1, 2023

We are committed to providing you with the best quality medical care and welcome conversations about our professional fees at any time. The fees charged reflect the level of professional skill required, the complexity of your presenting complaints and medical history, and the time spent evaluating and treating you.

INSURANCE

Billing of insurance is a courtesy we provide to our patients and is not required by law. Please provide us with a copy of your current insurance card and a photo ID at your every visit and whenever there is a change in insurance. We may occasionally ask for additional copies. It is your responsibility to have knowledge of your annual deductible, co-pays, and out of pocket maximum. If your insurance company does not respond to us within 30 days of our submitting a claim, the balance will become your responsibility.

We will bill your primary insurance, and bill secondary insurance for any line item with a balance greater than $10. If you have balances smaller than $10, we ask that you pay us and submit claims to your secondary insurance for reimbursement.

CO PAYS

Your co-pay is determined by your insurance carrier. Your insurance contract requires that we collect your co-pay at the time of service when you check in to be seen. Please be prepared to pay your co-pay at each visit. THIS APPLIES TO SHOT VISITS AS WELL.

REFERRALS

If your insurance plan requires a referral from your primary care provider or "Passport Provider" it is your responsibility to confirm that we have received it. If the referral is not complete, you may be required to reschedule, and/or the charges may become your full responsibility.

MISSED APPOINTMENT FEE

We are instituting a $50 fee for missed appointments. We understand that schedule changes arise and respectfully request 24 hours' notice of your need to cancel an appointment so that we may keep our appointment slots filled. This $50 fee will be billed to your insurance carrier; it is your responsibility. This fee applies to all patients, regardless of insurance provider or coverage status.

NSF FEE

A fee of $30 will be charged to your account if your check is returned for insufficient funds.

SELF PAY/UNINSURED

We will collect a $200 deposit on the day of your appointment before being seen by the provider. The balance will be collected following your appointment.

HIGH DEDUCTIBLE PLANS

If you have not met your deductible, or do not know if you have met your deductible, we will collect a $200 deposit from you on the day of your appointment before being seen by the provider. The balance will be collected following your appointment.

ACCOUNTS WITH OUTSTANDING BALANCES

If you have an outstanding balance at the time of your appointment, we need to collect that balance, or a portion of that balance up to $200, before you may be seen by the provider.

Patient Initials____________

PAYMENT PLANS

Once you receive a statement from our practice, please pay in full upon receipt. For your convenience, we accept cash, personal checks, debit and credit cards and Care Credit to assist you in paying your balance in full. If you cannot pay your balance in full, a short-term payment plan may be created to pay your balance over 3-6 months. You may be sent a letter stating the budget plan and the terms of re-payment.

COLLECTIONS

We refer accounts to an outside collection agency if we fail to obtain payment through usual methods of mailing patient statements to the account guarantor. Please keep us informed of address and phone number changes which helps us to stay in contact with you.

If your account is referred to our collection agency, any further visits to our practice will require your payment in full at the time of service. We will still bill your insurance for the visit and issue you a refund if necessary.

By signing below, you indicate your understanding that in the event any unpaid balance is placed for collections with any third-party collection agency, a fee of 33.333% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 33.333% and the additional costs and charges listed above represent the actual costs incurred by Carl E. Thornblade, MD, PLLC to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

By signing below, I agree that I have read and agree to this financial policy.

______________________________ ________________

Responsible party signature date

______________________________ ________________

Responsible party name, printed date

____

Patient name (if different from Responsible Party)

______________________________ ________________

Staff signature date

ALLERGY HISTORY QUESTIONNAIRE
CARL THORNBLADE, MD

MEDICATION INSTRUCTIONS: ***If you have chronic hives, DO NOT stop antihistamines.*** Benadryl and other store brand antihistamines and decongestants must be stopped at least three days prior to skin testing. Antihistamines that need to be stopped for 7 days prior to testing are XYZAL, ZYRTEC, CLARITIN, CLARINEX, and ALLEGRA. If you have concerns about stopping any of your medications, please feel free to contact our office at (406)728-6472 and we will be happy to address any questions or concerns.

Please complete this questionnaire and bring it with you to your appointment. If the question does not apply to you or the patient please fill in "N/A"

Patient Name:______________________________ Age:________ Birth date:________________
Parents Name (if patient is a minor):____
Address:____ Phone:________________
Referring Physician:____

A) When was the last time you took an antihistamine? __________________ Name of antihistamine: ____________

B) List of current medications (prescription and over the counter medications)

Name of Drug	Dosage (10mg, 2 puffs, etc)	How often taken (daily, as needed, etc)

C) List any medications including antibiotics that you are allergic to or are intolerant to ____________________________
____

D) **Reason for Evaluation**

1. Please summarize briefly, what are your ***MAIN*** concerns (this is the most important question.):

2. What symptoms do you feel may be due to an allergy? ______________________________________
____

3. Age symptoms began? _______

E) **If patient wheezes, complete the following:**

1. With what symptoms does the wheezing problem begin? ______________________________
2. List the symptoms which then appear in order of ______________________________________
occurrence:____
3. At what age did the wheezing begin? ____
4. Has it improved? _________ Worsened? ________To what do you attribute this?__________________
5. When do the symptoms seem worse? All Year _____ Spring______ Summer_______ Fall______ Winter_______
6. Wheezing episodes occur _______ days per week during wheezing periods.
7. When does the wheezing usually occur? Morning __________ Afternoon _________ Evening __________
8. How long does the wheezing period last? ____

9. How often are the severe wheezing episodes? ______________________ How long do the severe episodes last? ____.

10. Check the items which apply: Occasional wheezing _____ frequent wheezing ______ Constant wheezing _______ Cough leading to wheezing ______ Fever with wheezing ______ wheezing with exertion ______ Chest pain with wheezing _______

11. What medications have been used to control the wheezing and how effective is each? ________________________ ____

12. Did any medications cause any problems?____

13. Has any of the following been given to control the wheezing? Adrenalin ________ Cortisone or cortisone-like drugs? ____

14. Has the severity of an attack requires hospitalizations? No ___ Yes____ When? ____________________________ Where? ________________________________

F) **Nose**

1. Check the items which apply to nasal symptoms: Itching of nose or mouth _____ Nasal congestion _____ Clear nasal discharge______ Colored nasal discharge ________ Fever with symptoms ______ Mouth breathing _______ Constant clearing of the throat ______ Sneezing ______ Bad Breath ______ Post nasal drip _______ Loss of smell _____ Nasal Polyps _____ Snoring ______ Sinus infections ______
2. At what age did these symptoms start? _______________
3. When do the symptoms seem worse? All year ______ Spring _____ Summer _____ Fall ____ Winter _______
4. What medications have been used to control these symptoms and how effective is each? ___________________________ ____

G) **Infections**

1. How many "colds" occur per year? ___________ With wheezing? __________
2. How often does tonsillitis occur each year? _______ With wheezing? ______ Has patient had tonsillectomy? (yr) _____ Adenoidectomy? (yr)________
3. Have there been episodes of Croup?____ Bronchiolitis ?_____ Bronchitis?____ Pneumonia ?____Chest infections (date of last) ____________
4. What antibiotics have been used to treat infections? ____

H) **Headaches**

1. Seldom_____________ Occasionally ________Frequent____________
2. Contributing factors? ____

I) **Eye Complaints**

1. Check symptoms that apply to you or the patient: Frequent itching _______ Frequent redness and or tearing ______ Swelling of eye lids________ Discharge from eyes _______ Sensitivity to light _____ Blurring of vision _____ Burning sensation ______
2. How often have these symptoms been a problem within the past year? ____________________________________

J) **Ear Complaints**

1. Check symptoms that apply to patient: Frequent earaches ______ Loss of hearing _______ Ear infections_________ Dizziness______ Discharge from ears________

K) **Skin**

1. Check symptoms that apply to patient: Eczema _____ When? ___________ Due to what? _______________________ Recurrent Rash _____ Hives ____ When? __________ Due to what? ______________Cold water hives or swelling ____ Frequent skin infections (impetigo) __________________________ Dry or itchy skin? _____________________________

L) **Foods**

1. Check any of the following that foods cause: Itching of lips or mouth _______ Itching of the skin _____ Hives __________ Eczema _____ Rash _____ Headaches ______ Runny Nose ______ Nausea/vomiting _____ Wheezing ______ Stomach Cramps ______ Diarrhea ______ Other? ____
2. Have any foods been eliminated from the diet? ____
3. Did this change the severity of symptoms? ____
4. Is there a large intake of any particular food or beverage? ____

M) Precipitating factors of coughing, wheezing, nasal congestion, or sneezing

1. Check the items or situations that will cause any of the above symptoms to start or become worse:

____Outdoors
____Wet weather
____Dry clear weather
____Change from clear to rainy
____Change from rainy to clear
____Sudden change in temp
____Onset of cold weather
____Change in humidity
____Sudden chilling
____Cold feet
____Exertion
____Fatigue
____Laughing
____Coughing
____Emotional upset

____Child discipline
____Home/indoors
____Cleaning house
____Contact with old furniture
____Attic/basement
____Air conditioning
____Contact with dogs or cats
____Contact with other animals
____Contact with feathers/wool
____Newly mowed grass
____While on vacation
____Seashore
____Boat/airplane ride
____School/work/recreation
____Being in the woods/mountains
____Car ride

____Road dust
____Cosmetics/perfume
____Hairspray
____Hair shampoos/rinses
____Hand/facial lotions
____Body/facial powders
____Toothpaste/tooth powder
____Aspirin
____Laundry soap powder
____Flour dust
____Insect dust/sprays
____Fertilizers
____Smoke or odors
____Old leaves
____Flowers
____Other

____Same everywhere
____January
____February
____March
____April
____May
____June
____July
____August
____September
____October
____November
____December

2. Does anything from the list above (or anything else) cause improvement or worsening of symptoms?
____

N) Problems the symptoms create for the patient:

1. Is there limitation of work? ____________ Exercise? __________ Play? ______________
2. Due to what symptoms? ____
3. How many work/school days were missed during the past year due to this problem? ____________
4. Have there been any long periods of freedom from symptoms? ____________________
5. To what do you attribute this? ____
6. Is there any place where the patient is symptoms free? ___________________________

O) Residence when onset of symptoms occurred

1. State ______________________ Date of resident ______________________________
2. Symptoms were: Seasonal __________ Year round __________ How severe? ______________

P) Previous allergy evaluations

1. Place where evaluated before? ______________________________ Date ____________
2. What were the results? ____
3. Have allergy injections been received in the past? No____ Yes ____ Give the start and stop dates of desensitization __________ to ___________
4. What was the composition of the allergy injections? ____________________________
5. Was there any improvement after having the allergy injections of a period of time? ____No ____ Yes
6. Other studies done: ____

Q) Allergic Reactions

1. What type of reaction when stung by a bee or wasp? ______________________________
2. What medication did you take? ____
3.Did you have to go the hospital?________________________ Where?_________________

R) Personal Medical History

1. List any other medical conditions:
____
____
____
____
____

2. Does the patient have a heart condition or heart arrhythmia? (please specify)________________
3. Check immunizations that have been completed: DPT series__________ Polio series _______ MMR ______ Hepatitis B series____ Varicella _______ Hib series_____ Flu shot ____ Date of last Flu Shot?______________ Pneumovax_______ Date of last pneumovax___________

S) Family History

	Father	Mother	Brothers	Sisters
1. Age				
2. Hay Fever				
3. Asthma				
4. Eczema				
5. Hives				
6. Sinus Trouble				
7. Heart Condition				

8. Does any member of the family have a chronic illness? (specify)________________
9. List any other medical problems you feel may be of importance.________________
10. Is there any family member deceased?________________ Cause?________________
11. Does any illness seem to occur on either side of the family? ________________

T) Environmental History (where patient lives and what he/she is exposed to)

1. Residence: Check which applies to your home Urban___ Rural___ Farm___ Older house___Newer house___ Apartment___
2. Does the home have an attic? (describe) ________________ Basement? (describe)________________
3. Is the home near a factory? (describe)________________ Farm? (describe) ________________
   Fields or wooded areas? (describe) ________________
4. Type of trees in your yard and neighborhood?________________
5. Type of grass, flowers, or shrubs in the yard? ________________
6. Check which applies to the residence's heating system: Central ____ Hot water _____ Electric _____ Gas _____ Wood _____
7. Check which applies to the residence's cooling system: None ____ Central AC ____ Window unit AC ___ Swamp cooler _____
8. What kind of pets are in/out of the home? ________________
9. What kind of house plants are in the home? ________________
10. Does anyone smoke in the home or car? Yes______ No________ Specify________________
11. Is there any place in the home where the patient's symptoms are worse?________________
12. Check the following that pertain to the patient's bedroom: Heat or cooling vents____ Overstuffed furniture ____
    Stuffed toys ____ Cosmetics/ powders/ hairspray ____ scented products (e.g. candles, potpourri) ____ out of season clothes in Closet ____ airtight covers for pillows or mattress _____
13. Check and describe type for any of the following items that are in the patient's bedroom:
    Carpet/ rug pad: ________________
    Throw rugs: ________________
    Curtains: ________________
    Mattress: ________________
    Pillows: ________________
14. Number of beds in room: ___________ Number of persons sleeping in room ________________
15. Is there mold growing anywhere in the house (describe)?________________
16. Is there anything in your house or yard/around residence that has not been mentioned that you think is significant in contributing to the patient's symptoms?________________
17. What changes have you implemented to the patient's environment to improve his/her symptoms?________________
    ____

U) Other Comments:

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Wear glasses
Date of last exam ______
__ Infections
__ Injuries
__ Glaucoma
__ Cataracts
__ Blurred vision
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat
__ Wear hearing aids
Date of last exam_______
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds
__ Sinus problems
__ Sinus infections
__ Sinus headaches
__ Throat infections
__ Difficulty swallowing
__ Lip or mouth sores
__ Sore throats

Respiratory
__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Shortness of breath
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest
X-ray_____

Cardiovascular
__ Chest pain
Date of last EKG _______
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal
__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Colon, liver, stomach cancer
__ Hepatitis

Hematologic
__ Anemia
__ Hemophilia
__ Easy bleeding / bruising __
Swollen glands

Genitourinary
__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or
cervical cancer

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Stroke
__ Mini-stroke
__ Memory problems
__ Concentration problems
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems
__ Bleeding tendencies

Immunologic
__ Environmental allergies
__ Hay fever
__ Food allergies
__ Immune system problems
__ Connective tissue disease
__ Frequent colds / infections

Skin
__ Eczema or psoriasis
__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram
____

Musculoskeletal
__ Broken bones
list:______________
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain
__ Arthritis

Psychiatric
__ Anxiety
__ Depression
__ Manic/Depression
__ Schizophrenia
__ Considering suicide /
homicide
__ Panic attacks
__ Sudden mood swings
__ Emotional difficulties
__ Insomnia
__ Other psychiatric problems
__ Under psychiatric care