

Welcome to EXEMPLAR Allergy and Asthma

Your Appointment is on _____ (date) at _____ (time). Your Appointment is with:

_____ Dr. Sally Dee

_____ Dr. David Goetz

_____ **BRIDGEPORT:** 153 Main Street,
Bridgeport WV 26330. Phone: (304) 848-2400
 (Exit 119 off I79. 50E. Across from Benedum Center)

_____ **MORGANTOWN:** 1063 Maple Dr. Suite 1A,
Morgantown, WV 26505. Phone: (304)598-2992 (Mon/Wed/Fri)
 (Off Route 705; "bubble windows" bldg opposite ACE Hardware)

_____ **FAIRMONT:** 100 Avery Olivia Way, Suite B,
Fairmont, WV 26554. Phone: (304) 333-1650 (Tue/Thur)

Toll free number for all offices: 877-643-4700

(Pleasant Valley Road; across from Myer's Business Park)

Checklist before Your Allergy/Immunology Appointment

1. Forms to be Completed and Brought to Appointment.

1. MEDICAL HISTORY FORM

On the Medical History Form, not all questions on the three pages may apply to you. Page 3 applies to everyone, so please fill in all the information on page 3.

2. REGISTRATION FORM (Personal and Insurance Information)

3. (If it applies) **Consent Form for Patients less than 18 years-old** to be accompanied by someone other than a parent/guardian. See bottom of the "EXEMPLAR OFFICE PATIENT POLICIES"

2. **Stop Antihistamines and medications which would interfere with skin testing**, 3 to 5 days before your appointment. See the "MEDICATIONS WHICH INTERFERE WITH SKIN TESTING" list below. Do NOT stop your other medications, including: asthma medication, antibiotics, blood-pressure, and other essential treatments. If uncertain, please call your doctor or call us at the telephone numbers above.

Other forms that are attached:

1. **General Information for Exemplar Allergy, Asthma, and Immunology**
2. **Exemplar Office Patient Policies**

Medications Which Interfere with Skin Testing

Prescription Medications: Antihistamines: Discontinue **3-5 days** prior to skin testing.

Examples: Astelin, Atarax, Atrohist, Benadryl, Bromfed, Claritin (loratadine), Clarinex, Codimal, Dimetane, Hycomine, Kronofed, Nolahist, Nolahist, Rynatan, Periactin (cyproheptadine), Rynatuss, Semprex, Sinulin, Trinalin or Optimine, Vistaril (hydroxyzine), Xyzal, Astelin, Astepro, Patanase, Patanol, Pataday, Bepreve, Optivar, other antihistamine nasal sprays/eye drops/tablets.

Other medications having antihistamine activity which may interfere with skin testing: *these medications may need to be discontinued prior to skin testing, but only after discussions with your allergist and your prescribing physician.* Examples: Amitriptyline (Elavil, Etrafon, Limbitrol, Triavil), Desipramine (Norpramin), Doxepin (Sinequan), Imipramine (Tofranil), Nortriptyline (Pamelor), Protriptyline (Vivactil), Trimipramine (Surmontil)

Over-the-counter Medications: Cold, flu, sinus, and allergy preparations: Discontinue **3-5 days** prior

Examples: Actifed, Alka-Seltzer (cold & sinus), Allegra, Allerest, Benadryl (diphenhydramine), Children's Tylenol (cold & flu), Chlor-Trimeton (chlorpheniramine), Comtrex, Contac, Coricidin, Dimetapp (brompheniramine), Drixoral, Novahistine Elixir, PediaCare (cough & cold), Robitussin (cold), Sine-Off, Sinutab (sinus & allergy), Sudafed (sinus & allergy), Tavist (clemastine), Teldrin, Triaminic, Tylenol (cold, sinus, allergy, flu), Vick's (cold), Zyrtec (cetirizine)

Night-time pain relievers/sleeping aids: Discontinue **3-5 days** prior to skin testing

Examples: Bayer PM, Doan's PM, Excedrin PM, Nytol Caplets, Tylenol PM, Unisom Sleep Aid

CONTINUE ALL OTHER MEDICATIONS: antibiotics, blood pressure medications, lipid medications, steroids such as prednisone or Medrol dose-pack, nose sprays (except Astelin), etc. We may not be able to skin test you at the first appointment if you have been on systemic steroids (oral or injected prednisone, Medrol, etc.) for 2 or more weeks in the previous month. If you can not be skin tested at the first appointment, you may be skin tested at a subsequent follow-up when you are off antihistamines for 3 to 5 days and off systemic steroids for 2 weeks before testing.

General Information for Patients of Exemplar Allergy, Asthma, and Immunology

We are very pleased that you have selected Exemplar Allergy for your allergy/immunology assessment. This introduction to our clinic is designed to inform you about our background and policies, and familiarize you with some of the tests and treatments we use for allergies and asthma. Our practice is open to patients of all ages.

QUALIFICATIONS

Both Dr. David W. Goetz and Dr. Sally Dee are certified by the American Board of Allergy and Immunology (of the American Board of Medical Specialties). Dr. Goetz is also board certified in Clinical Laboratory Immunology.

ALLERGY CONSULTATIONS

We are ready to help you with a wide variety of allergy, asthma, and immunology problems, including: allergic rhinitis (hayfever), asthma, food allergy, immunodeficiencies, bee/wasp/yellow jacket/ant venom allergy, latex allergy, reactions to some medications (e.g. local anesthetics), reactions to immunizations, urticaria (hives) and angioedema, allergic fungal sinusitis, as well as other allergy related problems.

YOUR PRIMARY CARE PHYSICIAN AND CONTINUED CARE

It is imperative that you have a primary care provider who takes care of your day-to-day medical needs, managing infections, emergency medical conditions, hospitalizations, and providing your routine medical care. We will work closely with your primary care provider in treating your allergic/immunologic or asthmatic problems. However, since we travel among offices in northern West Virginia and will not always be present in your local area, your primary care provider should be your first contact for routine and emergency care. Usually we will see you for an initial consult and possibly one or two follow-up visits. Thereafter, your primary care physician will continue your treatment plan. If you are prescribed allergen vaccine shots, you will be seen in the Allergy Clinic for yearly reevaluations.

SKIN TESTING

Skin testing is the most sensitive method for identification of the allergenic immunoglobulin, IgE. Exemplar Allergy provides the newest, gentle and rapid methods of prick skin testing. Our standard allergen panel tests for tree, grass, weed, mold, and environmental allergen sensitivity. Skin testing can also be done for foods, latex, Hymenoptera (bee/wasp/vespid/ant) venoms, topical anesthetics, certain drugs, and other allergens. Please be sure that you have stopped taking any antihistamines for 3 to 5 days before your appointment, because these drugs (Claritin, loratadine, Zyrtec, Allegra, Xyzal, Benadryl, Dimetapp, CTM, and others) interfere with skin testing. In addition to not taking antihistamines for 3 to 5 days, we may not be able to skin test you at the first appointment if you have been on systemic steroids (oral or injected prednisone, Medrol, etc.) for 2 or more weeks in the previous month. If you can not be skin tested at the first appointment, you may be skin tested at a subsequent follow-up when you are off antihistamines for 3 to 5 days and off systemic steroids for 2 weeks before testing.

SPIROMETRY

If asthma is suspected, we will measure your lung function using a spirometer. This is an easy test in which you take a deep breath and blow as hard, and as long, as you can. The test results are important in both the diagnosis and treatment of asthma.

TREATMENTS FOR ASTHMA AND ALLERGIES

When formulating an allergy or asthma treatment plan for you, we begin with avoidance of identified allergens and irritants. Beyond environmental management and several useful "home remedies", there are a variety of medical treatments available. Some medications relieve symptoms, while others attack the allergic process itself. Allergen vaccines (allergy shots) may be appropriate for some patients. Our goal is to help you find the best, most effective treatments that relieve your symptoms.

ALLERGY SHOTS

For some patients, allergen immunotherapy may be prescribed in addition to appropriate oral and nasal medications. Allergy shots are effective treatment for certain selected individuals with allergic rhinitis (seasonal or perennial hayfever) and asthma. Allergen immunotherapy cannot be given at home or to patients on beta-blocker medications. Shots must be given in a medical office with the proper emergency equipment for treating reactions, which may occur after receiving allergy shots. Similar to other immunizations, after receiving an allergy injection there is a 30-minute waiting period before leaving the medical facility. We are available to give allergy shots in each of our offices in Morgantown, Bridgeport, and Fairmont; however, many patients prefer to receive their immunotherapy vaccines (allergy shots) at their primary care provider's office for convenience. (04/08)

**EXEMPLAR Allergy and Asthma
 MEDICAL HISTORY FORM (All patients please complete this 3 page form)
 Please fully fill out any section that applies to you (circle or fill in the answer)**

Name _____ Age _____ Male / Female Date _____

My primary reason for this appointment: nose or eye allergy / sinus problem / asthma / cough / welts or hives / edema or swellings / persisting rash / other reason: _____

Referred by: friend / myself / doctor: _____ (We'll send report to this Dr.)

1. NOSE, EYE, OR SINUS PROBLEMS

My Symptoms (circle) How Long have you had this problem? _____ (years/months)
 Itchy/watery/red eyes Worst season: all year spring / summer / fall / winter
 Itchy nose or sneezing Known causes: _____
 Runny nose/post nasal drip _____
 Nasal congestion Symptoms BETTER: indoors / outdoors / on vacation / other _____
 Throat clearing Times when symptoms BETTER: _____
 Sinus pressure/pain Medications that HELP: _____
 Frequent headaches How many sinus infections a year? _____
 Upper teeth hurting Sinus CAT Scan (date/result): _____
 Bad breath Sinus surgery?(date/result): _____
 Loss of taste/smell ENT surgeon who treated you: _____
 Hypertension? Yes / No Beta-blocker medication used? Yes / No
 Allergy testing last done (year) _____ where? _____
 Treated with allergy shots? From _____ to _____ Did allergy shots help? Yes / No Stopped because: _____

2. PULMONARY RESPIRATORY SYMPTOMS

Do you have asthma? Yes / No Who currently manages your asthma? _____
 Hospital admission for asthma? Yes / No (when?) _____
 Recurrent cough? Yes / No for how long? _____ Wheezing? Yes / No for how long? _____
 Rescue inhaler (albuterol) use how often? _____ times per day, or _____ times per week. Wake to use at night? Yes / No
 Exercise causes?: Short of breath / cough / wheeze Heartburn/acid reflux? Yes / No Reflux at night? Yes / No

3. ENVIRONMENTAL ALLERGENS AND IRRITANTS

Circle any of the following which aggravate your nose/sinus/lung or skin problem:
 House dust/cleaning Wood stove Cold air Humidity/Weather changes
 Hay/grass/mowing lawn Tobacco smoke Cats, dogs Strong odors/fumes Anxiety
 Other animals or allergens _____ Chemicals? _____
 Other? _____

4. ALL PATIENTS please complete this Section

Allergic to bee, yellow jacket or wasp sting? (please describe reaction) _____
 Smoker? Yes / No How many years? _____ How many packs per day? _____ Are there other smokers at home? Yes / No
Medical conditions (not already listed) briefly: _____

Surgeries you have had in the past (with approximate year): _____

Are your **immunizations** up to date? Yes / No Immunization allergy? _____
 Do you get a flu shot yearly? Yes / No Had the Pneumovax (pneumonia) shot? Yes / No when last? _____

Family history: Do parents, brothers, sisters, or your children have the following: (circle)
 Asthma, Hay fever, Nasal allergy, Sinus, Eczema, Emphysema, Cystic Fibrosis, Lupus, Arthritis, Thyroid

Home: Do you live in a: House / Apartment / Mobile Home _____ **Home Near:** Lake / Woods / Factory / Farm _____
 Has your home had any water damage/flooding or excessive mold growth? _____
 Humidifier used? Yes / No Home Airconditioned? Yes / No **Bed:** mattress/waterbed _____
Home Heating (all that apply): Forced Air / Hot water / Baseboard / Wood stove / Other _____
Pests? Ladybugs? Yes / No Cockroaches? Yes / No Other? _____
Indoor Pets: Cats? # _____ Dogs? # _____ Birds? _____ Reptiles? _____
 Other pets: _____
Outdoor Pets/Animals (list type): _____
School: Child patient's current grade in school _____ Adult patient's current school if any _____
Patient's Occupation (adults only) _____ Hobbies _____

5. Complete if your problem includes: **URTICARIA (Hives) / ANGIOEDEMA, ECZEMA, or RASH**

If your problem does NOT include skin problems, please check here 0 and CONTINUE ON PAGE 3

My skin problem includes: ___ itching, ___ hives, ___ swelling? OR ___ eczema/dermatitis/severely itchy skin?
 How long ago did skin problem begin? _____. I last had skin problem _____.
 Continuous? Yes / No. OR Episodic skin problem occurs every _____ hrs/days/weeks/months.
 Where on the body do they occur? _____. They look like? _____.
 Do they change location within a day? _____. When gone, do they leave marks in the skin? Yes / No.
 Things that might cause them? _____
 Are it/they caused by: ___ heat? ___ cold? ___ pressure? ___ tight clothing? ___ sun light? ___ vibration? ___ exercise?
 ___ anxiety? ___ latex? ___ water? ___ food? kind: _____ medication/vitamin? (list : _____)
 Other? _____

Associated symptoms? (circle):
 NONE, asthma, wheezing, throat tightness, nausea/vomiting/diarrhea, fainting/dizzy, nasal polyps, other _____
 Medications which helped control _____ Medications which did **not** help them. _____
 Number of Emergency room visits? _____ Treatment given: _____
 Other treatments or tests done by other doctors for this problem: _____

NSAIDS used (circle): Aspirin, ibuprofen, Motrin, Advil, Naprosyn, Orudis, Relafen, Tolectin, Voltaren, Ponstel, Indocin, Clinoril, Other _____ **How often** do you use an NSAIDS? Daily, every-other-day, weekly, monthly, ____.

List **medications** which were **new** for you in the 8 weeks before hives/angioedema/rash began:
 Medication: _____ Started _____ days before skin condition began. Still taking? Yes / No.

On page 3 you will list medications you are **allergic to** and what happens if you take the medication.
 List here **medications** which you feel are causing your hives/angioedema/rash:
 Med: _____ causes: _____. Med: _____ causes: _____.

List all **illnesses/colds** which you had in the 8 weeks before hives/angioedema began:
 Illness _____ ;Treatment _____. Started _____ days before hives/etc. Chronic? Yes / No.
 Illness _____ ;Treatment _____. Started _____ days before hives/etc. Chronic? Yes / No.

Do you or someone in your family have one of the following:
 Thyroid problems ___ you ___ family Asthma, allergies, eczema ___ you ___ family Other personal or
 Hepatitis (liver disease) ___ you ___ family Chronic swellings ___ you ___ family family conditions:
 Autoimmune disease ___ you ___ family Lupus or vasculitis ___ you ___ family _____
 Athletes foot ___ you Fungus infection ___ you ___ family _____

Do you have problems with feeling cold, constipation, unusually fatigued? _____
 Before rash began did you change soaps, detergents, cosmetics, hair products, cleaning products?: _____
 Bath/shower Soap brand _____.

Do you use fabric softeners? type _____ Dryer sheets? type _____
 Changes in job/school? _____ New pets or hobbies? _____

6. ALL PATIENTS please complete this Section
Medication List and Medication / Food / Latex Allergy Questionnaire

1. Medications Currently Used: (If you cannot complete the list, bring all bottles/labels to your appointment.)

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		

2. Medication Allergy If you have NO medication allergies please check here and go on to number 3.

1. Medication	2. Allergic Reaction	3. Oral/IV/Topic	4. Dose	5. Month/Year	6. Repeated?

3. Food Allergy If you have NO food allergies please check here and go on to number 4.

List all food you do not tolerate & what reaction occurs if you eat or touch the food.:

<u>Food</u>	<u>Reactions</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Latex Allergy/Sensitivity

Latex is the pliable/stretchable material made from the sap of the rubber tree and used in balloons, condoms, elastic bands, padding, and medical materials.

- Have you ever had a latex reaction or been told you have an allergy or a sensitivity to latex? Yes / No
- Have you ever had swollen lips or throat after blowing up a balloon or having dental work? Yes / No
Describe if yes: _____
- Have you ever had a reaction (rash, swelling, itching of hands or eyes, hives, difficulty breathing) after being in contact with any of the following (circle all that apply):
 Rubber/latex gloves Ace bandages Elastic in clothing Foam pillows
 Rubber bands Erasers containing latex Condoms or diaphragms
- Do you have a congenital condition, such as spinal bifida, myeloma, or myelodysplasia? Yes / No
- Had multiple procedures involving the spine or use of multiple catheters before 1-year old? Yes / No
- Are you allergic to the following foods: (circle) bananas, avocados, kiwi fruit, or chestnuts?

EXEMPLAR, INC. REGISTRATION FORM

1063 Maple Dr. Suite 1A, Morgantown, WV 26505
100 Avery Olivia Way, Suite B, Fairmont, WV 26554
153 Main Street, Bridgeport WV 26330

(304) 598-2992 Fax: 304-598-5901
(304) 333-1650 Fax: 304-333-1651
(304) 848-2400 Fax: 304-848-2401

PATIENT INFORMATION

Patient Name (Last, first, middle)
Street City State Zip
Home phone (AC) Email address
Date of birth Social Security Number
Place of employment or school Tele #
Primary Care Physician (PCP)
Street City State Zip
PCP telephone #:
Pharmacy City/location Tele #

REFERRED BY Heard about Exemplar from:

(Please fill out below if patient is a child)

Father's name Date of birth
Place of employment
Work phone Social Security Number
Mother's name Date of birth
Place of employment
Work phone Social Security Number

INSURANCE INFORMATION

Primary insurance company
Address
Policy Holder's Name: Policy Holder's date of birth:
Policy Holder's Social Security Number:
Insured's (Patient's) I.D. No. Group Number
Is this an employers insurance plan?
Secondary insurance company
Address
Policy Holder's Name: Policy Holder's date of birth:
Policy Holder's Social Security Number:
Insured's (Patient's) I.D. No. Group Number
Is this an employers insurance plan?

PLEASE READ AND SIGN BELOW

I authorize any holder of Medical or other information about me to release to the Social Security Administration and HealthCare Financing Administration or its intermediaries or carriers, or to the billing agent of the physician, any information needed for this or related claim. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signed Date

Exemplar Office Patient Policies

Welcome to our office. We are pleased that you have chosen Exemplar for your medical care. In order for us to provide the quality care that you expect in an efficient manner, we must insist that you read and comply with the following policies.

1. We require reasonable notification (24 hours when possible) of cancellation or rescheduling of all appointments. **If three (3) appointments are missed without notification**, we will, unfortunately have to terminate our patient relationship.
2. **All insurance cards (including Medicaid)** need to be available at the time of each appointment. If the insurance card information is not available for two (2) appointments, you will need to have that visit rescheduled.
3. **If you arrive over 15 minutes late for your appointment**, the appointment will have to be rescheduled.
4. If you (the patient) are 17 years old or younger, you must be accompanied by a parent or legal guardian. A Consent Form signed by a parent or legal guardian is required if the under-18y/o patient is accompanied by another adult. This is a legal requirement and no exceptions will be made. (Please fill out the Consent below and sign.)
5. If you do not have insurance and are paying with check or credit/debit card, **you need to pay a minimum of half of the charges at the time of each visit.** The remainder will be due in 30 days.
6. Exemplar offices operate on a cash-less basis. We accept VISA or MASTERCARD (credit card or debit card) or check with proper identification.
7. Authorizations (from your insurance company), if necessary, are also your responsibility and are required on the date of service. Please contact your primary care physician or insurance company with any questions. All co-pays, co-insurance, and deductibles are due in full at your appointment. For questions concerning billing you may contact our billing office: AMBS (Blue Team) at: 800-294-7001 or 304-363-7000.

Consent for Child less than 18 years old to be Seen in the Allergy Clinic If accompanied by someone other than parent/guardian.

I _____, (Parent or legal guardian's name) give
 _____ (Person accompanying minor patient (must be 18yr or older))
 permission to have minor child less than 18 years old _____ (Patient's name)
 seen and given medical care by Exemplar Inc. (AKA, Exemplar Allergy) providers.

Parent or legal Guardian signature

Date

Witness signature

Date