MASSACHUSETTS GENERAL HOSPITAL

Allergy and Immunology

Yawkey Center for Outpatient Care
55 Fruit Street, Yawkey 4B
Boston, MA 02114
Tel: 617-726-3850
Fax: 617-724-0239

Dear Patient,

A new patient appointment has been made for you at Allergy Associates, MGH

We ask that all patients bring the following:

- Photo ID
- Insurance card
- Prescription plan card
- Completed paperwork
- Co-payment
- Insurance Referral from your Primary Care Physician, it is the patient's responsibility to obtain. Patients who are seen without a referral will be asked to sign a waiver and may be billed directly.

If you are unable to keep your appointment:

- Please notify our office at least two (2) business days prior to your scheduled office visit. This allows us to schedule other patients who are waiting for an appointment.

New patient visits:

- **Please allow ample travel time.** Please arrive **15 minutes before** the scheduled time of your appointment to be checked in. If you are **more than 15 minutes late** for your appointment, you may be asked to reschedule to a later date.

- May take as long as **3 hours** because of the time required for skin testing. Your initial examination may include a series of skin tests to identify allergens to which you are sensitive.

- **For patients scheduled for skin testing, all antihistamines should be avoided for 5 days prior to your office visit.** Common prescription antihistamines include: Allegra (fexofenadine), Clarinex (desloratadine), Astelin /Astepro (azelastine hcl) nasal spray, Patanase nasal spray, Vistaril and Atarax (hydroxyzine). There are numerous over-the-counter antihistamines like Benadryl, Chlotrimeton, Zyrtec (cetirizine), Claritin/ Alavert (loratadine), and Tylenol PM. If you are not certain whether the medication you are taking is an antihistamine, please contact us at 617-726-3850.

- If you are unable to stop taking antihistamines because of the severity of your symptoms, continue on the medication but keep your appointment. Another approach to testing will be considered by your doctor.

- Please wear a sleeveless shirt for skin testing, as test reagents will be placed on both the upper and lower parts of the arms.

- Please update your registration prior to your visit by calling 1-866-211-6588.

Please visit our website at http://www.massgeneral.org/west/ourservices/allergy.aspx.

We look forward to seeing you.

MGH Allergy and Immunology

Patient Information

(Please fill out all forms completely prior to your appointment or <u>it may delay you being seen by the physician.</u>) *If you need a language interpreter to fill out the forms please arrive 30 minutes before your scheduled appointment and request an interpreter.*

Patient's Name _____ date of birth ____/____/_____

Please provide your pharmacy information in order for your provider to electronically send prescriptions to your pharmacy, which is the Hospital's preferred method.

<u>Local</u> Pharmacy Name_____

Pharmacy address (street and city) _____

<u>Mail</u> Order Pharmacy Name and Phone Number _____
Pharmacy address (street and city) _____

Who referred you to Allergy Associate?
_____ Referred by physician (list name of referring MD) _____
_____ Other (please describe) _____

In order to send written reports to your health care providers, or to discuss your case with them, we need your permission. Please list here all doctors with whom you would like us to correspond. **If you do not want reports sent to any providers, please list this clearly in writing.**

Primary care provider name _____
Address _____
_____
Phone number of PCP _____ Fax number of PCP _____

Other health care providers whom reports should be sent:

Name _____	Name _____
Specialty _____	Specialty _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____

☐ Please check box if you are interested in being contacted about research studies which may be related to your health problem.

Patient signature _____ Date ____/____/____

MGH Allergy and Immunology Patient Information
Please complete <u>all forms</u> before your appointment.

Name: _____ Date of birth ____/____/____

Check the box that states the <u>main</u> reason for your visit.
□ Allergic reaction
□ Rash
□ Nasal allergy symptoms
□ Asthma
□ Sinus problem
□ Food allergy
□ Medication allergy
□ Reaction to insect sting
□ Hives
□ Swelling/Angioedema
□ Recurrent infections
□ Others: (Please list) _____

If you have nasal allergy symptoms, what do you think brings on your symptoms?
_____
If you have asthma symptoms, what do you think brings on your symptoms?
_____
When are your symptoms the worst? (please circle)
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
Year Round
When are your symptoms the worst? (please circle)
At night Mornings Evenings At Home At Work Indoors Outdoors
Have you been tested for allergies in the past?_____ If so, what were you allergic to?_____

Home environment
Please check <u>all</u> the boxes that describe your environment.
How long have you lived in the Boston area? _____
Have you moved recently? □ Yes □ No
How long have you been in your current home? _____
How old is your current home? _____
Do you have:
□ feather pillows □ down comforter □ wall to wall carpeting
Type of heating □ Forced hot water □ Forced hot air □ electric baseboard
Air conditioning □ none □ Central □ Window
Is there:
□ Visible mold, mildew or dampness in your home Where? _____
□ Evidence of cockroaches
□ Evidence of mice
Do you have a pet?
□ Cat(s) □ Dog(s) □ Does your cat or dog go into the bedroom?
□ other pets (list) _____

Work environment
Occupation_____ How long? _____yrs.
Are there any features in your work environment that you feel are contributing to your problem?
_____

Do you have any hobbies that might be contributing to your problem?_____

Have you ever smoked?_____ Age that you started _____ Age Quit ____ packs per day___
Does anyone in your household smoke? _____

MGH Allergy and Immunology Patient Information
Please complete all forms before your appointment.

Name: _____ Date of birth ____/____/____

List medications, vitamins and herbal supplements you are taking. Include all prescriptions and over the counter medications.	
drug name/dose/frequency	drug name/dose/frequency

Are you allergic to any medications?

Drug name	Symptoms	Date of Reaction

Family History

	Asthma	Seasonal Allergies	Sinus Disease	Eczema	Hives	Swelling/ Angioedema	Food Allergy	Medication Allergy	Autoimmune Disease	Known Immune Problem	Frequent Infections
mother											
father											
sister											
brother											
children											
other											

□ Adopted □ Family history unknown

Past Medical History

Please put a check the appropriate box.

Do you have any of the following?	Yes	No	Do you have any of the following?	Yes	No
High blood pressure			Autoimmune disease		
Diabetes			Thyroid problem		
Heart problems			Hospitalization for infection		
Liver problems			Pneumonia		
History of cancer			Sinus infections		
History of seizures			Ear infections		
Acid reflux disease			Hives		
Sinusitis			Eczema		
Nasal Polyps			Unexplained swelling		
History of sinus surgery			Reaction to insect sting		
Chronic congestion			Other: _____		

MGH Allergy and Immunology Patient Information
Please complete <u>all forms</u> before your appointment.

Name: _____ Date of birth ____/____/____

Have you had any of these symptoms recently?
Please put a check the appropriate box.

General	**Yes**	**No**	**Gastrointestinal**	**Yes**	**No**
Fever or chills			Trouble swallowing		
Unexpected weight change			Bloating/Indigestion		
Swelling			Abdominal pain		
Enlarged lymph nodes			Heartburn/reflux		
Other: _____			Nausea or vomiting		
Eyes			Diarrhea		
Itchy watery eyes			Black, tar-like stools		
Red eyes			Constipation		
Recent change in vision			Other: _____		
Pain in eyes			**Genitourinary**		
Other: _____			Problems with urination		
Ears/Nose/Throat			Problems with periods (women)		
Ear Pain/popping			Other: _____		
Hearing difficulty			**Endocrine**		
Post nasal drip			Constant thirst		
Runny nose			Heat intolerance		
Sinus pain or pressure			Cold intolerance		
Nose bleeds			Other: _____		
Other _____			**Bone/joints**		
Cardiovascular			Painful joints		
Palpitations/irregular heartbeat			Swollen joints		
Chest pain			Muscle pain/tenderness		
Swollen ankles			Other: _____		
Other _____			**Neuromuscular**		
Respiratory			Weakness in arm/leg		
Shortness of breath			Difficulty with balance		
Chest tightness			Dizzy, fainting spells		
Persistent cough			Other: _____		
Wheezing			**Psychological**		
Other: _____			Increased stress		
Skin			Depression		
Rashes			Anxiety		
Hives			Difficulty sleeping		
Dry skin			**Pain**		
Sensitive skin			Do you have any pain that may be related to your allergies?		
Bruising easily			If *no*, do not continue any further with questionnaire. If *yes*, state the location of your pain _____ _____		
Other: _____					

No Pain				**Quite a lot of Pain**						**worst pain imaginable**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**