MASSACHUSETTS GENERAL HOSPITAL

MGH Waltham
Allergy and Immunology
52 Second Ave., Blue Bldg., Suite 2600
Waltham, MA 02451

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Dear Patient,

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

Date:____________________ **Day:**________________ **Time:**_______________

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 781-487-3838.

- 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.

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From Boston (West Bound)

Take the Massachusetts Turnpike West to exit **123 A/B (formerly 15 A/B)** and follow instructions below for Route 95/128 Northbound.

From Framingham/Natick (East Bound)

Take the Massachusetts Turnpike to exit **123 (formerly 14)** and follow instructions below for Route 95/128 Northbound

From Route 95/128 Northbound:

Take exit **43B (formerly 27B)** Winter St. Waltham. You will pass the Mass General Waltham building on the left of the highway. Turn right off the exit, then right over the highway. Proceed straight through the first set of lights and left through the second set. The Embassy Suites Hotel should now be on your right. Stay in the right lane and follow the signs for Second Ave./Bear Hill Rd. Turn right, and then left into the parking garage of the Mass General Waltham Building.

From Route 95/128 Southbound

Take exit **43B (formerly 27B)** Winter St. Waltham and stay in the center lane off the exit. Proceed straight through the first set of lights, and then left through the second set. The Embassy Suites Hotel should now be on your right. Stay in the right lane and follow the signs for Second Ave./Bear Hill Rd. Turn right, and then left into the parking garage of the Mass General Waltham Building.

From Route 93 North or South

Take the Route 95/128 south exit and follow instructions for Route 95/128 Southbound.

Parking & Wheelchair Access

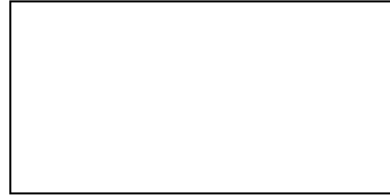
There is ample free parking on site, and all Mass General Waltham offices are handicapped accessible

Upon entering the driveway, get in the right lane and follow the signs for P1, P2, P3. There is access to the Blue Building with elevators on all three levels. Once in the elevator, come up to the second floor. Allergy and Immunology is in Suite 2600 (behind the spiral staircase).

Due to construction and heavy traffic,

please allow extra travel time.

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 all forms before your appointment.

Name: ______________________________ Date of birth ____/____/____

Check the box that states the main 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 all 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 all forms 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.		
Other:__________________________			If *yes*, state the location of your pain _______________		
			____		

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