

ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES OF TAMPA BAY

www.allergytampa.com

RICHARD F. LOCKEY, M.D. ROGER W. FOX, M.D. DENNIS K. LEDFORD, M.D. MARK C. GLAUM, M.D., Ph.D.

Please complete front and back of form.

DATE _____ SOCIAL SECURITY # _____

PATIENT'S NAME _____ CIRCLE: MR. MRS. MS. MISS

CIRCLE: MALE / FEMALE DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

STREET ADDRESS & APT. # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # () _____ CELL # () _____ DRIVER'S LICENSE # _____

E-MAIL ADDRESS _____

PATIENT'S PLACE OF EMPLOYMENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK TELEPHONE # () _____ EXT. # _____

(IF PATIENT IS UNDER 18, PLEASE COMPLETE)

PARENT OR GUARDIAN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME TELEPHONE # () _____ WORK TELEPHONE # () _____

PRIMARY CARE PHYSICIAN _____ TELEPHONE # () _____

PRIMARY PHYSICIAN'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____

TELEPHONE # () _____

RELATIONSHIP TO YOU _____

WORK TELEPHONE # () _____

Present all insurance / pharmacy cards to the receptionist.

INSURANCE # 1 - PRIMARY

NAME OF INSURANCE CO. _____

HMO PPO OTHER _____

CO. ADDRESS _____

PHONE # _____

MEMBER # _____

GROUP # _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SSN _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S DATE OF BIRTH _____

COPAY OR PERCENTAGE OF AMOUNT _____

INSURANCE # 2 - SECONDARY

NAME OF INSURANCE CO. _____

HMO PPO OTHER _____

CO. ADDRESS _____

PHONE # _____

MEMBER # _____

GROUP # _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SSN _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER'S EMPLOYER _____

POLICY HOLDER'S DATE OF BIRTH _____

COPAY OR PERCENTAGE OF AMOUNT _____

*Please Note That Workers' Compensation Cases must Be Preauthorized by Management.

over →

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If you have a medication prescription plan, please complete:

Name of pharmacy company _____

ID# _____ Phone # _____

AUTHORIZATIONS

1. CONSENT FOR MEDICAL TREATMENT: I AUTHORIZE ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY (AAIATB) TO FURNISH THE NECESSARY MEDICAL TREATMENTS, PROCEDURES, DRUGS, AND SUPPLIES AS ORDERED. I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT, DIAGNOSTIC PROCEDURES, AND EXAMINATIONS.
2. STATEMENT OF FINANCIAL RESPONSIBILITY: I HEREBY AGREE TO PAY AAIATB FOR ALL CHARGES (TO INCLUDE CO-PAYS, DEDUCTIBLES, PERCENTAGES, AND HEALTH SAVINGS ACCOUNTS) AT THE TIME OF SERVICE; HOWEVER, I UNDERSTAND THAT AAIATB MAY ACCEPT ASSIGNMENT OF INSURANCE BENEFITS IN LIEU OF EQUAL AMOUNT OF PAYMENT. THE FULL AMOUNT OF ALL CHARGES NOT PAID BY THE INSURANCE COMPANY WILL ULTIMATELY BE MY RESPONSIBILITY. I REALIZE THAT IF A BALANCE IS DUE NECESSITATING THE USE OF A COLLECTION AGENCY, I AGREE TO PAY ALL COLLECTION COSTS, INCLUDING ATTORNEY FEES AND FEES ON APPEAL.
3. OUR BILLING AND COLLECTION PROCEDURES REQUIRE THAT THE SOCIAL SECURITY NUMBER OF THE INSURED/RESPONSIBLE PARTY BE PROVIDED.
4. NOTICE OF PRIVACY OF PROTECTED HEALTH INFORMATION RECEIVED AND CONSENT IS GIVEN TO RELEASE MEDICAL RECORDS TO OTHER HEALTH CARE PHYSICIANS.

WELCOME, WHY DID YOU SELECT OUR PRACTICE? (Complete as applicable)

- REFERRED BY DR. _____ REFERRED BY MY INSURANCE COMPANY
- REFERRED BY ANOTHER PATIENT _____ ADVERTISEMENT (circle one) our website / phonebook / internet

DATE _____ PATIENT OR GUARDIAN'S SIGNATURE _____

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY

Richard F. Lockey, M.D.
 Roger W. Fox, M.D.
 Dennis K. Ledford, M.D.
 Mark C. Glaum, M.D., Ph.D.
 13801 Bruce B. Downs Boulevard, Suite 502
 Tampa, Florida 33613 - (813) 971-9743
 Billing: Ext. 111
 www.allergytampa.com

FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we will work with you. The fo

- Our office participates in a variety of insurance plans. **It is your responsibility to:**
 - **Bring your insurance card at each visit.**
 - **Be prepared to pay your co-pay, deductible, or co-insurance at the time services are rendered, to include high deductible health plans (HSA). Payment can be made by cash, check, or we accept Visa and Master Card.**
 - **Payment in full is expected at the time services are rendered.**
- If you have insurance with which we are not contracted, we will file the claim if you have out-of-network benefits, any deductible or co-insurance that you are responsible for is due at the time of service. If your insurance does not provide out-of-network benefits, then you are responsible for payment in full.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance based on hardship guidelines. Please so inform us prior to your visit. Financial hardship cases are for patients without medical insurance.
- Referrals: It is your responsibility to provide required referrals prior to the visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible for payment in full.
- If the patient is 18 years or younger, the patient’s legal guardian must sign below. When a minor is seen, all the same rules and regulations apply.
- A \$50.00 charge is assessed to patients who do not cancel a scheduled appointment within 48 hours or do not come for their visit (no-shows).

Our practice firmly believes that a good physician/patient relationship is based on understanding and good communications. Questions about financial arrangements should be directed to the front office.

I have read and understand this financial policy.

Signature of Patient or Responsible Party	SSN/DOB	Date
-------------------------------------------	---------	------

Signature of Co-Responsible Party	Date
-----------------------------------	------

Richard F. Lockey, M.D.
Roger W. Fox, M.D.
Dennis K. Ledford, M.D.
Mark C. Glaum, M.D., Ph.D.

Adult and Pediatric
Allergy, Asthma and Immunology

Diplomates American Board
of Allergy and Immunology

13801 Bruce B. Downs Blvd.
Suite 502
Tampa, FL 33613
813/971-9743

ACKNOWLEDGMENT

I, (print patient's name) _____, acknowledge that I have received a copy of the Notice Regarding Privacy of Personal Health Information from Allergy, Asthma and Immunology Associates of Tampa Bay.

Patient's Signature

Date

Height _____ Weight _____

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY**Richard F. Lockey, M.D.****Roger W. Fox, M.D.****Dennis K. Ledford, M.D.****Mark C. Glaum, M.D., Ph.D.****13801 Bruce B. Downs Boulevard, Suite 502****Tampa, Florida 33613 - (813) 971-9743****www.allergytampa.com****MEDICAL HISTORY AND ALLERGY SURVEY**

NAME _____ AGE _____ DATE _____

NAME OF PERSON COMPLETING FORM IF NOT COMPLETED BY PATIENT _____

NAME OF PRIMARY CARE PHYSICIAN (PCP) _____ + _____

NAME OF REFERRING PHYSICIAN (IF OTHER THAN PCP) _____

INSTRUCTIONS: YOU MUST COMPLETE THIS FORM. OUR INSURANCE REQUIRES THAT IT BE DONE. **YOU WILL NOT BE SEEN UNLESS IT IS COMPLETED.** THERE ARE **8** PAGES. PLEASE COMPLETE ALL PAGES.

1. **CHIEF COMPLAINT:** What are the main symptoms which are bothering you?

2. **NOSE, THROAT, AND SINUSES:**

Do you or did you ever have nose, throat, or sinus problems? Yes ___ No ___ If yes, answer below; if no, go to #3.

When did you first have trouble with your nasal symptoms? What age were you? _____ Season? _____

Check the following symptoms that you are having

___ sneezing	___ hoarseness
___ itching of the nose or roof of the mouth	___ decreased smell
___ nose rubbing	___ decreased taste
___ clear nasal discharge	___ itchiness inside ears
___ post nasal drip	___ nose bleeding
___ colored nasal discharge	___ snore
___ frequent nose blowing	___ sore throat in the morning
___ nasal stuffiness	___ you clear your throat often
___ mouth breathing	___ heartburn
___ frequent throat clearing	___ wake up with heartburn
___ sore throat	___ belch a lot
___ yellow or green discharge in your throat	

Do some of your nasal symptoms occur almost every day throughout the year? Yes ___ No ___

Are your nasal symptoms worse during any particular season or time of day?

i.e., (1) mild, (2) moderate, or (3) severe (fill in number):

January _____	May _____	September _____
February _____	June _____	October _____
March _____	July _____	November _____
April _____	August _____	December _____

Morning _____ Afternoon _____ Evening _____ Night _____ All _____ CONTINUE TO NEXT PAGE

Have you ever had any of the following problems? (Check)

Yes ___ No ___ sinus infection

Yes ___ No ___ nasal polyps

Yes ___ No ___ frequent headaches - Where? front ___ temples ___ eyes ___ back ___

If yes, do you frequently chew gum? Yes ___ No ___ Have you had braces? Yes ___ No ___

Yes ___ No ___ aspirin induced nasal symptoms

Yes ___ No ___ nasal surgery - When? _____ Last? _____

Yes ___ No ___ frequent "bad colds"

Yes ___ No ___ frequent tonsillitis - How many times per year? _____

Check one of the following statements that best describes the severity of your nasal symptoms when they are at their worst:

___ mild ___ severe
___ moderate ___ very severe

How many school or work days have you missed in a year's time due to these problems?

What medicines have you taken to control your eye and/or nose symptoms?

Are you taking any of these medicines every day? _____

Generally, how much relief from your symptoms do you get by taking these medicines?

___ Excellent ___ Good ___ Moderate ___ Very little ___ None

What nose drops or sprays are you using? _____

Have you had a CAT scan of your sinuses? Yes ___ No ___ When _____

3. EARS: Have you ever had any of the following ear symptoms? (Check)

Yes ___ No ___ If no, go to #4.

Yes ___ No ___ frequent ear infections

Yes ___ No ___ are you dizzy?

How many within the past year? _____

Yes ___ No ___ are you lightheaded?

Yes ___ No ___ is your hearing impaired

4. EYES: Have you had any of the following eye symptoms ? (Check)

Yes ___ No ___ If no, go to #5.

Yes ___ No ___ itching

Yes ___ No ___ light hurts your eyes

Yes ___ No ___ redness

Yes ___ No ___ yellow discharge from eyes

Yes ___ No ___ tearing

Yes ___ No ___ eyelid swelling

Yes ___ No ___ dryness

Yes ___ No ___ eyelid irritation

Yes ___ No ___ burning

How often have these symptoms been a problem within the past year?

Circle correct answer: never; some; a lot; extreme.

5. LUNGS: If you do or have had asthma, please answer the questions.

If you have never had wheezing or lung problems, you may skip this question and proceed to #6.

When did you first begin to have wheezing spells?

Age? _____ Season? _____

CONTINUE TO NEXT PAGE

Check the following symptoms you are having:

- Yes ___ No ___ mild to moderate wheezing episodes
- Yes ___ No ___ severe wheezing episodes
- Yes ___ No ___ does this limit your exercise or play?
- Yes ___ No ___ during or after exercise?

Is your wheezing worse during any particular months or time of day? (Mark yes or no)

January _____	May _____	September _____
February _____	June _____	October _____
March _____	July _____	November _____
April _____	August _____	December _____

Morning ___ Afternoon ___ Evening ___ Night ___

With your wheezing do you usually have:

___ fever ___ cough ___ tightness in your chest?

Do you usually have a cold or chest infections when you wheeze?

Can you have a normal "bad cold" without you then developing chest congestion and wheezing? _____

How many times during the past year have you had to visit your doctor (or hospital emergency room) because of your wheezing?

How many times have you been hospitalized due to your wheezing? _____

When were you last in the hospital for this? _____

How many school or work days have you missed this year due to your wheezing?

What medicines are you taking to control your wheezing? _____

Do you use inhaler(s)? _____ How often? _____

Which one(s)? _____

Have you required cortisone (prednisone, Medrol, etc.) drugs for control of your wheezing in the past? Yes ___ No ___

How many times? _____ Date last used: _____

Do you ever have any of the following symptoms? (Check)

- | | |
|--------------------------------------------------|---------------------------------------------------|
| Yes ___ No ___ frequent coughing spells | Yes ___ No ___ coughing on exertion |
| Yes ___ No ___ recurrent night cough | Yes ___ No ___ coughing then wheezing |
| Yes ___ No ___ coughing up mucus (color? _____) | Yes ___ No ___ coughing with laughing |
| Yes ___ No ___ shortness of breath with exercise | Yes ___ No ___ coughing with lying down |
| Yes ___ No ___ blood in mucus | Yes ___ No ___ coughing with talking on the phone |

6. CHEST INFECTIONS:

As an infant or child, did you have asthma? Yes ___ No ___

X-rays: Have you had a chest x-ray within 5 years? Yes ___ No ___

If so: Date of last chest film _____ Where x-ray obtained _____

7. ALLERGIC SKIN PROBLEMS:

Have you ever had eczema? Yes ___ No ___ If no, go to # 8.

When last? _____

What parts of your skin were affected? Arms _____ Legs _____ Face _____ Body _____

8. PREVIOUS ALLERGY EVALUATIONS:

Have you ever had an allergy evaluation in the past? Yes ___ No ___ If no, go to #9.

If you have, then complete the following questions:

What age were you when you had your first allergy evaluation? _____

Which doctor and where? _____

If you have had skin testing, to what were you found to be allergic?

_____ trees _____ weeds _____ dust _____ foods
_____ grasses _____ molds _____ feathers _____ others

If you have received a series of allergy shots in the past, please give the inclusive dates:

If you are on allergy shots now, how often are you taking them?

What improvement have you (did you) note(d) in your symptoms while on allergy shots:

_____ marked improvement (almost complete clearing of your symptoms)

_____ moderate improvement _____ no improvement

Did you ever have an allergic reaction to your shots? Yes ___ No ___

If yes, what happened? _____

9. FACTORS WHICH MAY CONTRIBUTE TO YOUR ALLERGIC PROBLEMS

In the following questions, 1-7, check the factors that you think will make your nose symptoms or wheezing (asthma) start or become worse. Otherwise, go to #10.

- | | | | |
|-------|--------------|--------------------------------|--------------|
| (1) | <u>Lungs</u> | <u>Infections</u> | <u>Nasal</u> |
| _____ | | a "viral bad cold" | _____ |
| _____ | | a respiratory infection | _____ |
| (2) | | <u>Weather</u> | |
| _____ | | change in weather | _____ |
| _____ | | wet, rainy weather | _____ |
| _____ | | onset of cold weather | _____ |
| _____ | | being in the wind | _____ |
| (3) | | <u>Inhalant Allergens</u> | |
| _____ | | playing in or mowing the grass | _____ |
| _____ | | musty smells | _____ |
| _____ | | exposure to house dust | _____ |
| (4) | | <u>Hormone</u> | |
| _____ | | menstruation | _____ |
| _____ | | pregnancy | _____ |
| (5) | | <u>Physical Factors</u> | |
| _____ | | air conditioning | _____ |
| _____ | | cold air | _____ |
| _____ | | getting up in the morning | _____ |

CONTINUE TO NEXT PAGE

(6) <u>Lungs</u>	<u>Smells</u>	<u>Nasal</u>
_____	exhausts, fumes	_____
_____	smoke	_____
_____	perfumes, cosmetics	_____
_____	cleaning agents	_____
_____	cooking odors	_____
(7) _____	<u>Miscellaneous</u>	
_____	birds	_____
_____	cats	_____
_____	dogs	_____
_____	other animals	_____
_____	feather pillows	_____

10. INGESTANTS: Do you know of any foods, drinks, or medicines that will make your nose symptoms or wheezing start or cause it to become worse? (Circle and add items.)

Yes ___ No ___ If no, go to #11.

Foods (milk, egg, wheat, nuts, peanut, shellfish, soybean) _____

Drinks (beer, wine) _____

Medicines (aspirin) _____

11. DRUG ALLERGY:

Have you ever had an allergic reaction to any of the following drugs?

Yes ___ No ___ If no, go to #12.

_____ penicillin	_____ tetracycline	Others _____
_____ sulfa drugs	_____ "mycins" (erythromycin)	_____
_____ aspirin	_____ Levaquin, Cipro, Floxin	_____
_____ Ceclor (cephalosporin)	_____ codeine, morphine, Demerol	_____
_____ tetracycline		

12. INSECTS:

Have you ever had an allergic reaction to an insect? Yes ___ No ___ If no, go to #13.

_____ bee	_____ yellow jacket	_____ fire ant	_____ other
_____ wasp	_____ hornet	_____ deer fly	

What happened?

Local swelling Yes ___ No ___

Hives, swelling, itching over the entire body Yes ___ No ___

Other _____

When did the last reaction occur? Approximate date _____

CONTINUE TO NEXT PAGE

ENVIRONMENTAL FACTORS If does not apply, go to #14.

(1) Location:

(X) Where your symptoms are worse. (✓) where your symptoms are better.

_____ indoors _____ outdoors _____ at home _____ at school or at work
 _____ in air conditioning _____ away from home _____ the same at all locations

(2) Environmental Exposure: Check the following items that best describe your surroundings:

Residence

How long have you lived in your present dwelling? _____ years

Bedroom

_____ wall-to-wall carpet
 _____ carpets in bedroom, how old _____?
 Type of mattress? Regular _____ Water _____
 Type of pillow? Dacron _____ Feather _____
 Does your mattress or pillow have airtight covers? Yes _____ No _____

Is there mold growing in your house? _____ If yes, where? _____

What kind of animals (birds also) do you have? _____

Are they indoors at any time? Yes _____ No _____ How many years? _____

14. PERSONAL-SOCIAL FACTORS (EVERYONE MUST ANSWER COMPLETELY)

What is your occupation? _____

Does anyone practice any hobbies or occupations in your home that produce vapors, or dust, or strong odors? Yes _____ No _____

If yes, what? _____

Do you smoke cigarettes? Yes _____ No _____ How many cigarettes per day? _____

Did you ever smoke? Yes _____ No _____ How long? _____ years. Average of how many packs per day? _____

Does anyone smoke in your home? Yes _____ No _____ How many persons? _____

Do you abuse alcoholic beverages? Yes _____ No _____ More than 2-3 drinks per day? _____

Do you use illicit drugs (confidential)? Yes _____ No _____

15. FAMILY HISTORY (EVERYONE MUST ANSWER COMPLETELY)

	living/deceased Father	living/deceased Mother	How many? Brothers	How many? Sisters	How many? Children
Does any of your family have any of the following illnesses? (Check)					
Hay fever					
Asthma					
Eczema					
Hives					
Sinus trouble					
Any other illnesses?					

Is any family member deceased? _____ Cause? _____

Do any illnesses seem to run on your father's or mother's side of the family?

Diabetes, hypertension, heart disease, stroke, other? _____

16. PAST HISTORY (EVERYONE MUST ANSWER COMPLETELY)

(1) Have you ever had any of the following illnesses?

- | | | | |
|----------------------------------------|--------------------------------------------------|--------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> ulcer disease | <input type="checkbox"/> rheumatic heart disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> heartburn | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> high risk for AIDS |
| <input type="checkbox"/> cancer | <input type="checkbox"/> radiation therapy | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> sleep apnea |

(2) What surgery have you had? (tonsillectomy, nasal surgery, etc.) Approximate dates:

(3) Have you had any serious illness or injuries which led to hospitalization?

Yes _____ No _____ List type and year: _____

(4) Have you received the Pneumovax vaccine? Yes _____ No _____ Do not know _____

(5) Do you receive the yearly flu vaccine? Yes _____ No _____ Do not know _____

Please list all medications you take and the dose, including over-the-counter medications:

- | | |
|-----------|------------|
| (1) _____ | (6) _____ |
| (2) _____ | (7) _____ |
| (3) _____ | (8) _____ |
| (4) _____ | (9) _____ |
| (5) _____ | (10) _____ |

REVIEW OF SYSTEMS (EVERYONE MUST ANSWER COMPLETELY)

Do you have any of the following at this time? (Check)

General

- weight loss
- chills
- fevers
- loss of appetite
- fatigue
- poor memory
- fall asleep during the day
- snoring is a problem

Skin

- rashes on feet
- rashes in groin
- rashes between legs
- rashes between toes

Musculoskeletal

- morning joint stiffness and aching
- painful, swollen joints
- muscle tenderness or pain
- muscle weakness

Gynecological

- excess bleeding
- change in menstrual cycle

Gastrointestinal

- nausea
- vomiting
- diarrhea
- change in bowel habits
- trouble swallowing (food gets stuck)
- heartburn
- black bowel movements
- blood in bowel movement

Cardiovascular

- chest pain
- chest pain with exercise
- calf pain with exercise
- ankle swelling

Endocrine

- cold intolerance
- heat intolerance

Kidney

- trouble starting urine
- bed wetting
- burning with urination
- loss of urine with cough or sneeze
- frequent urination during the night

Blood

- bleed or bruise easily
- swollen lymph nodes

Neurological

- weakness/clumsiness
- tingling, burning, or numbness of extremities

Psychological

- fearful, anxious
- excessive worry
- crying spells
- trouble sleeping
- behavior problems
- depression

Other

- lumps or bumps under arms
- lumps or bumps in breasts

Sleepiness Scale - Are you sleepy during the day? If so, complete the following using the appropriate numbers.

- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Chance of dozing

Situation of dozing / falling asleep

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

- Sitting and reading
- Watching television
- Sitting inactively in a public place (such as a theater or meeting)
- As a passenger in a car for an hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car, while stopped for a few minutes in traffic

Please add anything you wish which the questionnaire did not address.

To the best of my knowledge, I have answered the complete questionnaire.

Signature

Reviewed form with the patient in its entirety.

Richard F. Lockey, M.D.

Mark C. Glaum, M.D., Ph.D.

ASTHMA CONTROL TEST (ACT)

This form must be completed by the patient to comply with insurance requirements / documentation.

Please circle **ONE** answer for each of the **5** questions below and review your results with your physician.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work or at home?

All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5
-----------------	----------	------------------	----------	------------------	----------	----------------------	----------	------------------	----------

2. During the past 4 weeks, how often have you had shortness of breath?

More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5
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3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night, or earlier than usual in the morning?

4 or more nights a week	1	2 to 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5
-------------------------	----------	----------------------	----------	-------------	----------	---------------	----------	------------	----------

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	1	1 to 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5
-------------------------	----------	----------------------	----------	-----------------------	----------	---------------------	----------	------------	----------

5. How would you rate your asthma control during the past 4 weeks?

Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5
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TOTAL SCORE _____ (please enter score on the other side of this form)

If your total score is 19 or less, your asthma may not be as well controlled as it could be.

**YOU MAY PRINT THIS FORM PRIOR TO YOUR VISITS BY ACCESSING
www.allergytampa.com/medlist
THIS FORM MUST BE COMPLETED BY THE PATIENT BEFORE SEEING THE DOCTOR
TO COMPLY WITH INSURANCE REQUIREMENTS / DOCUMENTATION**

____ RICHARD F. LOCKEY, M.D.
____ DENNIS K. LEDFORD, M.D.

____ ROGER W. FOX, M.D.
____ MARK C. GLAUM, M.D., Ph.D.

PATIENT'S NAME _____ DATE _____

CHIEF COMPLAINT: _____

And/or circle items if applicable: Routine visit Need refills Sneezing Runny nose Itchy eyes Cough
Wheeze Asthma Respiratory infection Sinusitis Headache Fever Earache Discolored discharge

NEW PROBLEMS SINCE LAST VISIT: _____

PREVIOUS PROBLEMS: STABLE _____ OR WORSENING (describe) _____

LIST ALL MEDICATIONS AND THE DOSE PRESCRIBED TO YOU BY ALL PHYSICIANS WHICH YOU TAKE.

NOTE: WE CAN ONLY REFILL MEDICATIONS PRESCRIBED TO YOU BY US.

<u>MEDICATION</u>	<u>DOSE</u>	<u>TIMES TAKEN IN A DAY</u>	<u>✓ REFILLS (only if needed)</u>
1) _____			
2) _____			
3) _____			
4) _____			
5) _____			
6) _____			
7) _____			
8) _____			
9) _____			
10) _____			

PRESCRIPTIONS ARE HANDWRITTEN TO TAKE TO YOUR PHARMACY OR MAIL ORDER.
WE DO NOT CALL IN OR FAX PRESCRIPTIONS FROM OUR OFFICE.

IF YOU MAIL YOUR PRESCRIPTIONS, DOES YOUR INSURANCE REQUIRE A 90 DAY SUPPLY ? _____
OR, DO YOU FILL YOUR PRESCRIPTIONS AT A LOCAL PHARMACY ? _____

ANY ALLERGIES TO MEDICATIONS _____

have asthma? complete reverse side of form - ACT SCORE _____

FOR MEDICAL STAFF:

BP _____ P _____ R _____ HT _____ WT _____ PF _____ TEMP _____