All Allergy, Asthma & Immunology Clinic, P.A.

10216 Garland Road
Dallas, Texas 75218

Sonak B. Daulat M.D.

Please print and fill out completely. If you need help, please ask the receptionist.

Date:________________ Preferred pharmacy-name & number:____________________________

Patient Last Name: ______________ Patient First Name: _______________MI: _______ Birthdate________

Address: ____________________________ City: __________________ State: _____________ Zip: ________

Primary number (____)______________ **Email: ____**

Driver's License #: _______________ State: ___________ Sex: ______________ Age: ____________

Marital Status: ___ Single ___Married____ Legally Separated____ Divorced____ Widowed____ Other

Employer: ______________________ Work Phone: (_____)________________________ Ext:______

Name of party Responsible for payment, if other than Patient: _____________________________

DOB________ SS#____________ DL#______________ Employer __________ PH# ____________

Address of Responsible Party: _____________________ City: __________ State: _______Zip:______

Phone: (_____)____________________ Relationship of responsible party to patient_______________

Nearest relative not living with you: _________________________ Phone: (_ ___) _________________

Address of relative: ______________________ City: ________________ State: ________ Zip: _________

Please list other member of your family who are patients here and their relationship to you:

____

Who may we thank for referring you to our office? (Please specify by name) Doctor: _________________

Friend: _____________ Hospital: ______________ Insurance: _____________Family: ________________

What is your medical coverage? HMO_____ EPO/POS_____PPO_____ Work Comp ___Medicare: __________

Who is your PRIMARY CARE PHYSICIAN? ______________________ PH# ________________________

PRIMARY insurance ______________________ Group # ___________ Policy # ______________________

Claims address _______________________ City ___________ State ____ Zip ______ Ph#______________

Insured ____________________Relation to the patient _________________ Sex: Male Female

DOB of insured _________________ Employer ____________________

Emp. Address __________________________ City __________________ State _______ Zip_________

SECONDARY Insurance ___________________________ Group # _____________ Policy # _______

Claims address _____________________ City ___________ State ____ Zip ______ Ph#_____________

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FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREAMENT:

I authorize treatment of the person named above and agree to pay all the fees and charges for such treatment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process an insurance claim and also request payment of government benefits either to myself or the party who accepts assignment below.

Signature on file **X**____ **Date:** ______________________

IF PATIENT UNDERAGE OF 18: Dr. Sonak Daulat and his staff have permission to examine and treat.

Signature of parent or guardian: **X**____

Thank you for choosing my office for your health care needs. We look forward to serving you.

(214) 328-3232 • Fax: (214) 328-0202 • www.aaaic.net

Affiliated with White Rock and Baylor Scott & White Hospitals
Adjunct Professor U.T. Southwestern Medical Center

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Sonak B. Daulat M.D.
A.A.A.I.C.
10216 Garland Rd. Dallas, TX 75218
270 S. Collins Rd., #300 Sunnyvale, TX 75182
3600 Gaston Ave., #1056 Dallas, Texas 75246
Phone: (214) 328-3232 • Fax: (214) 328-0202

Patient Name: ______________________
Birthday: ______________________
Name of person completing form: ____________
Date: ______________________

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

THE MAIN REASON FOR THIS VISIT TODAY IS (ARE): (*CHECK ALL THAT APPLY*)

❑ **NASAL SYMPTOMS:**
- ❑ Sneezing
- ❑ Runny nose
- ❑ Nasal congestion
- ❑ Itchy, watery eyes
- ❑ Itchy nose
- ❑ Itchy roof of mouth
- ❑ Loss of sense of smell
- ❑ Frequent clearing of throat
- ❑ Itchy ears
- ❑ Frequent nasal bleeding
- ❑ Post nasal drip
- ❑ Bad breath
- ❑ Sore throat
- ❑ History of polyps or nasal septal deviation
- ❑ "Addiction" to nasal sprays
- ❑ Transfer of allergy care from Dr. ____________
- ❑ Continuation of allergy injections started ________ years ago.

❑ **ASTHMA SYMPTOMS:**
- ❑ Frequent cough
- ❑ Shortness of breath
- ❑ Wheezing or cough
  - ❑ At night – How often? ____________
  - ❑ With exercise
- ❑ Chest pain
- ❑ Rapid heart rate
- ❑ How many hospitalizations for asthma? ___
  - Date of last hospitalization ____________
- How many ER visits for asthma? __________

❑ **FREQUENT INFECTIONS:**
- ❑ Sinus infections
  - Number per year ______________
  - Date of last antibiotic ______________
- ❑ Ear infections
  - Number per year ______________
  - Date of last antibiotic ______________
- ❑ Pneumonia
  - Number in lifetime ______________
  - Date of last episode ______________
  - Date of Pneumovax injection __________
- ❑ Other infections
  - Please describe: ______________

❑ **FREQUENT HEADACHES:**
- ❑ History of migraine headaches
- ❑ History of tension headaches
- ❑ Triggered by known factors such as stress, caffeine, certain foods
- ❑ Associated nausea, vomiting or visual problems
- ❑ Have had a CAT scan – Date: ________
- Describe location ______________
- Describe frequency ______________

❑ **OTHER SYMPTOMS:**
- ❑ Insect sting reaction
- ❑ Skin rash – contact dermatitis
- ❑ Skin rash – eczema
- ❑ Abdominal pain or diarrhea

LIST OTHER CONCERNS OR SYMPTOMS HERE: ______________________________________
____
____
____

THESE SYMPTOMS OCCUR: (*Check all that apply*)

❑ Spring
❑ Summer
❑ Fall
❑ Winter
❑ Year – round
❑ Days or weeks at a time
❑ Worse at home
❑ Worse at work or school
❑ Worse in AM
❑ Worse in PM
❑ Worse outdoors
❑ All day

SYMPTOMS ARE MADE WORSE BY: (*Check all that apply*)

❑ Cold
❑ Cigarette smoke
❑ Mowing grass
❑ Raking leaves
❑ Dusting
❑ Perfumes
❑ Strong odors
❑ Alcoholic beverages
❑ Heat
❑ Exercise
❑ Animal danders
- ❑ cats
- ❑ dogs

❑ Other

LIST ALL CURRENT MEDICATIONS: (including vitamins, laxatives, Tylenol and aspirin)

Medication	Frequency
________________	________ times per day
________________	________ times per day
________________	________ times per day
________________	________ times per day
________________	________ times per day
________________	________ times per day
________________	________ times per day

LIST ALL PERVIOUS ALLERGY OR ASTHMA MEDICATIONS (including antihistamines such as Claritin. Seldane; nasal sprays such as Afrin, nasal steroid sprays such as Vancenase, Nasacort, or Flonase; and asthma medications including inhalers, theophylline, and nebulizer medications):

Medication				
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery
________________	❑ helped	❑ no help	❑ drowsy	❑ jittery

CURRENT ENVIRONMENT: *(Check if present)*

	YES	NO		YES	NO
Cats	❑	❑	Cigarette smoke	❑	❑
Dogs	❑	❑	Forced air heating	❑	❑
Birds	❑	❑	Air conditioning: central	❑	❑
Other pets	❑	❑	Air conditioning: window units	❑	❑
Feather pillows	❑	❑	Lots of house plants	❑	❑
Down comforter	❑	❑	Mold growth	❑	❑
Carpets or rugs	❑	❑	Improvement on trips	❑	❑
Air cleaner	❑	❑	Exposure to latex or rubber	❑	❑

Currently living in: ❑ a house ❑ an apartment ❑ a mobile home

Constructed of: ❑ brick ❑ frame ❑ mixed ❑ stucco/stone

Located in: ❑ the city ❑ the suburbs ❑ the country

Current residence is ________ years old. The carpet is _______ years old. The mattress is ________ years old.

Please list any areas of special concern (i.e. history of water damage, specific plants. pets. etc.):

____

____

____

____

PAST ALLERGY HISTORY:

Have you been allergy tested in the past? ❑ YES ❑ NO

If YES, answer the following questions:

Test by Dr. ____________________ in 19_____. Location of doctor: ____________________

Allergic to: ❑ trees ❑ grass ❑ weeds ❑ dust mites ❑ molds ❑ danders

❑ other ______________________________

Previous allergy shots? ❑ YES ❑ NO Still on shots? ❑ YES ❑ NO

Were (are) allergy shots helpful for you?: ❑ YES ❑ NO

Have you ever had a severe reaction to allergy shots? ❑ YES ❑ NO

Please describe history of the reaction: ______________________________

____

____

____

PAST MEDICAL HISTORY:

PLEASE LIST THE NAME AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN AND THE NAMES OF ANY OTHER PHYSICIANS WHOM YOU HAVE SEEN IN THE PAST 2 YEARS:

____
____
____

WOULD YOU LIKE A REPORT OF YOUR ALLERGY EVALUATION SENT TO YOUR PRIMARY CARE MD?

☐ YES ☐ NO

HOSPITALIZATIONS: (AGE OR YEAR)

__________ for __________
__________ for __________
__________ for __________
__________ for __________

SURGERIES (Include tonsillectomy, adnoidectomy, ear and nasal surgeries):

__________ for __________
__________ for __________
__________ for __________
__________ for __________

EMERGENCY VISITS: __________ times in the past year for __________
__________ Times in the past five years for __________

DRUG ALLERGIES (List the name of the drug and the symptoms it caused and approximate date):

__________ caused __________ in (year) __________
__________ caused __________ in (year) __________
__________ caused __________ in (year) __________
__________ caused __________ in (year) __________

ADVERSE REACTIONS TO IMMUNIZATIONS (Include reactions to flu shots, pneumonia shot, tetanus, diptheria, and measles).

__________ caused __________ in (year) __________
__________ caused __________ in (year) __________

OTHER CHRONIC HEALTH CONDITIONS (Include diabetes, hypertension, heart disease, elevated cholesterol, irritable bowel syndrome, hiatal hernia, thyroid disease, and nerve or psychiatric problems).

____
____
____
____
____

FAMILY HISTORY

	Allergies	Asthma	Frequent coughing	Frequent infections	Other Please list
Father	☐	☐	☐	☐	__________
Mother	☐	☐	☐	☐	__________
Brother(s)	☐	☐	☐	☐	__________
Sister(s)	☐	☐	☐	☐	__________
Grandfather(s)	☐	☐	☐	☐	__________
Grandmother(s)	☐	☐	☐	☐	__________
Uncle(s)	☐	☐	☐	☐	__________
Aunt(s)	☐	☐	☐	☐	__________
Cousin(s)	☐	☐	☐	☐	__________

SOCIAL HISTORY:

Children

(Complete this side if patient is less than 18 years old)

Birth Weight ______

Premature ❑ YES ❑ NO

Describe any complications of delivery ______

______

Development delays ❑ YES ❑ NO

Please describe ______

Breast fed ❑ YES ❑ NO

Diet and feeding concerns ______

______

Parents are: ❑ divorced ❑ separated ❑ both deceased ❑ married

Primary residence is ❑ one home ❑ split

Siblings (List names and ages):

______

______

______

______

Name of school or daycare: ______

Grade: ______

School performance:

❑ Outstanding

❑ Acceptable

❑ Unacceptable. Why? ______

______

______

Smoke exposure: ❑ YES ❑ NO

Place of birth: ______

Cities or states of residence since birth: ______

______

______

Adults

(Complete this side if patient is 18 years or older)

Place of birth: ______

Cities or states of residence since birth: ______

______

______

Current Occupation: ______

❑ Office setting

❑ Outdoor setting

❑ Other – please describe ______

Marital status: ❑ single ❑ married ❑ divorced ❑ separated

Children: ❑ YES ❑ NO How many? ______

Hobbies: ______

______

______

Do you smoke or have you smoked in the past:

❑ YES ❑ NO

How many per day ______

How many years ______

Quit when? ______

Do you need help quitting? ❑ YES ❑ NO

Alcohol consumption:

❑ Never

❑ Rarely

❑ On special occasions

❑ Moderate (weekly)

❑ Heavy

Drug use history

❑ Marijuana

❑ Cocaine

❑ Other

Do you engage in routine exercise?

❑ YES

❑ NO

❑ Sometimes

REVIEW OF SYSTEMS: *(Check all that apply)*

❑ fever
❑ weight changes ______ lbs.
❑ night sweats
❑ glaucoma ❑ cataracts
❑ visual changes
❑ deafness ❑ ringing in ears
❑ chest pain ❑ palpitations
❑ heart failure
❑ valvular heart disease (including Mitral Valve Prolapse)
❑ TB or pleurisy
❑ emesis
❑ jaundice
❑ heart burn
❑ kidney
❑ nausea
❑ inflammatory bowel disease
❑ diarrhea
❑ major depression
❑ recurrent urinary tract infections
❑ arthritis
❑ muscular disorders
❑ bruising
❑ seizures
❑ hair changes
❑ joint pain
❑ muscle pain
❑ mood disorder
❑ breast cancer
❑ strokes
❑ dry skin
❑ itching
❑ skin rashes
❑ diabetes

Please comment on boxes checked: ______

______

______

______

Thank you for completing this allergy/health history as accurately and as thoroughly as possible.

Signature of person completing this form: ______ **Date:** ______