CAARD
CENTER FOR ASTHMA, ALLERGY AND RESPIRATORY DISEASE, PLLC

EHD
EXETER/HAMPTON DIAGNOSTICS INCORPORATED

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may be and disclose your health information.

We may use and disclose you medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Contact at 65 Lafayette Road, North Hampton, NH 03862, ATTENTION: Practice Manager.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We, however, are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures to protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice will expire six (6) years from the date of signing.

This notice is effective as of July 25, 2012 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office.

You are recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Center for Asthma, Allergy and Respiratory Disease,
PLLC Exeter/Hampton Diagnostics, Inc.
65 Lafayette Road, 2nd Floor
North Hampton, NH
03862 (603) 964-3392

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human
Services Office of Civil Rights
200 Independence Avenue,
SW Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be available to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.
- Other (please list, such as spouse, parent/s . . .): Please print _____

_____

_____

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

NOTIFICATION OF LIABILITY

I have had the opportunity to read/receive a copy of the privacy policy of Center for Asthma, Allergy and Respiratory Disease, PLLC and hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or its representatives to release any and all information with respect to any illness or injury, medical history, consultation, prescription(s) or treatment and copies of all medical records to the physicians of Center for Asthma, Allergy and Respiratory Disease, PLLC. I also authorize Center for Asthma, Allergy and Respiratory Disease, PLLC, its physicians and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

Patient/Guardian signature _____ Date _____

I hereby assign benefits and authorize payment to go directly to Center for Asthma, Allergy and Respiratory Disease, PLLC for any medical service provided but not to exceed the reasonable and customary charges for these services. This office is not responsible for incorrect benefit information given to us by your insurance carrier or for changes in coverage. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company, the charges on your account will be your responsibility. I understand that I am financially responsible to the physician for all charges not covered by this agreement. Payment is due at the time services are rendered.

We accept Visa, MasterCard, Discover, American Express, personal checks and cash for your convenience. Knowing your insurance benefits are the responsibility of the insured and dependents.

Patient/Guardian signature _____ Date _____

A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Patient Bill of Responsibilities

Welcome to Center for Asthma, Allergy and Respiratory Disease, PLLC (CAARD). The following is our office policies and procedures. Please read carefully and sign. Also, feel free to ask our office staff if you should have any questions.

1. The office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m. Late night Thursday until 6:00 p.m. Closed Saturday and Sunday. Please plan your appointments, medication refills, or any other calls accordingly. Please be aware that your doctor is not always in the office during these hours.

2. Please keep your scheduled appointments**. The office requires a 24-hour notice if you are unable to keep your appointment**. The doctor's schedule may be booked up to 3-4 weeks in advance, making it difficult to reschedule. We cannot accommodate walk-in appointments.

   There will be an $85.00 charge billed to your account for appointments cancelled in less than 24 hours or for a no-show. For stress-testing appointments cancelled in less than 24 hours or for a no-show, a charge of $275.00 will be billed to your account. This fee must be paid prior to your next office visit. Frequent no-shows for appointments may result in dismissal from the practice.

3. There is no doctor on call if you become ill after hours and on weekends. **If you have a life-threatening emergency, please call 911 or go to the emergency room.**

4. Medication refill requests will be completed within 24 hours. **Please plan ahead**! No refills will be called in after office **hours or on weekends**. Note: the doctor may request to see the patient or an outstanding balance may need to be paid before refill requests are complete.

5. Messages received before 1:00 p.m. will be returned the same day. Calls after 1:00 p.m. may not be returned until the next business day. A nurse/medical assistant will return your call and relay your message to your doctor. The doctor will not be interrupted while in with patients.

   Please understand that your callbacks take time. **Remember to unblock your phones**. Time does not allow for repeated calls and busy signals. We will try your phone line twice.

   We will not be able to page you. Please leave a phone number where you can be reached.

6. There is no charge for the first set of records/radiological films going to another doctor. Repeat requests for records/films may incur a charge. The patient must sign a "release of records" before any records can be sent.

7. Consent to Photographs, Videotapes and Audio Recordings: I consent to photographs, videotapes, digital or audio recordings and/or images of me being recorded for security purposes and/or CAARD/EHD's healthcare operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

65 Lafayette Road • North Hampton, NH 03862-2480 • Phone: (603) 964-3392 • Fax: (603) 964-3396

8. The CAARD billing office will file claims with your insurance company for services provided. **Any charges not covered by your insurance company will be your sole responsibility.**

   Please notify CAARD immediately of any changes in your insurance coverage. We ask that you bring your insurance card with you for each visit.

   Due to the overwhelming number of insurance plans, it is impossible for our front desk to verify benefits. It is your responsibility to verify that CAARD is a member of your plan before presenting to our office for treatment. You are also responsible for obtaining a referral from your Primary Care Physician if required, prior to your scheduled appointment. If you have any questions, please call the customer service number on your insurance card.

9. Payment/co-payments are to be paid at the time of service. We accept cash, checks or credit cards (Visa, MasterCard, American Express and Discover) as well as CareCredit.

10. If you have an HMO insurance plan, it is your responsibility to obtain the necessary referral before services can be provided. Please contact your designated primary care physician in a timely manner. Most primary care physician offices require 72 hours to process referrals to specialists.

11. Patients electing to be seen out of network will be responsible for payment at the time of service.

12. A $10.00 late fee will be assessed monthly on account balances that become more than 30 days past due. Account balances remain in a current status as long as a payment is received each month.

13. In the event that an account is turned over to a collection agency, a collection fee (33% of balance) will be assessed, plus reasonable attorney fees, court costs, etc.

14. Any NSF/returned checks will be assessed a $35.00 (our cost $25.00 plus $10.00 administrative fee)

15. In situations of severe financial hardship, this office will consider making specials arrangements on a case-by-case basis. Please discuss this with our billing department immediately if this applies to you.

16. We are all here to serve. If you have remaining questions, our staff is ready to help find answers.

Thank you for your understanding and cooperation. We are very happy that you have chosen us for your asthma, allergy, and respiratory needs. We look forward to treating you in the future.

I have read and I understand the policies of the Center for Asthma, Allergy and Respiratory Disease, PLLC.

_____ _____

Signature Date

Insurances With Which We Are Contracted

- Aetna
- First Health
- Medicare
- PHCS Network
- United Healthcare
- Anthem
- Harvard Pilgrim
- MultiPlan Network
- Tricare/Healthcare
- Cigna
- Healthnet
- Federal
- MVP
- Tufts
- Fallo
- MA
- BC/BS
- NH
- Medicaid
- UniCare

Our billing department will be happy to answer any questions regarding charges and insurance participation. Please feel free to contact us at 603-964-3392 x13 or x11.

CAARD
CENTER FOR ASTHMA, ALLERGY AND RESPIRATORY DISEASE, PLLC

Mark R. Windt, M.D.

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient name: _____ DOB: ___/___/___

Address: _____

_____

Phone: _____

I authorize to disclose/release the following information (check all applicable)
Please give specific dates: from _____ to _____

☐ All records
☐ Abstract/Summary
☐ Laboratory/pathology records
☐ Pharmacy/prescription records
☐ X-ray/radiology records
☐ Sensitive health info.
(i.e. mental health, HIV/AIDs test results, sexually transmitted disease) _____

_____

Please send the records listed above to:

Name: Center for Asthma, Allergy and Respiratory Disease, PLLC
Address: 65 Lafayette Road
North Hampton, NH 03862
Phone: 603-964-3392 Fax: 603-964-3396

*This authorization will remain in effect for **one year** from the date of signature below, unless you specify a different date here: _____ (date). You or your personal representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.*

Signature

_____ _____
Signature of patient or patient's representative | Date

_____ _____
Printed name of patient representative | Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor)

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Medications that **Interfere** with **Allergy Skin Tests**

Certain over-the-counter prescription medications contain ingredients, which affect allergy skin tests. Make sure to check the labels of all your medications (including eye drops and nasal sprays) to determine if they contain any ingredients listed below. If you have any questions regarding ingredients, contact your pharmacist. The medications listed must not be used for at least the amount of time indicated below, prior to allergy skin testing.

The following **Eye drops** must be held at least **7 days** prior to tests:

Pataday, Patanol, Optivar, Zaditor, Alaway, Elestat, Olopatadine, Azelastine, Ketotifen, Epinastine

Pheniramine (Visine allergy eye drops) must be held for **48 hrs** prior to tests

The following **Nasal Sprays** must be held for at least **7 days** prior to tests:
Astelin, Astepro, Azelastine, Patanase, Olopatadine, Dymista.

Oral Medications	**Minimum time to be held Prior to allergy skin test**
Benadryl, diphenhydramine (allergy medications and non-prescription sleep aids)	**48 hrs**
Doxylamine, pyrilamine, pheniramine (in allergy, cold and sinus preparations)	**48 hrs**
Phenergan, Promethazine (in prescription cough syrups and anti-nausea)	**48 hrs**
Periactin, cyproheptadine (appetite stimulant and other uses)	**48 hrs**
Meclizine, dimenhydrinate, Antivert, Bonine, Dramamine (motion sickness)	**48 hrs**
Tagamet, Zantac, Pepcid, Axid, Cimetidine, Ranitidine, famotidine, nizatidine (indigestion, heartburn medications)	**48 hrs**
Chlor-Trimeton, chlorpheniramine (in allergy, cold, and sinus preparations)	**5 days**
Tussionex cough syrup (contains chlorpheniramine)	**5 days**
Zyrtec, Xyzal, Atarax, Vistaril, Cetirizine, Levocetirizine, hydroxyzine (allergy & itch)	**7 days**
Loratadine (in nonprescription allergy medications including Claritin and Alavert)	**7 days**
Allegra, Clarinex, Fexofenadine, BroveX, Lodrane, Brompheniramine, Desloratadine,	**7 days**
Remeron, mirtazapine (treatment of pain, depression, appetite stimulant)	**7 days**
Tricyclics (headache, neuralgia, other chronically painful conditions; Doxepin also used for itch)	**7 days**
Amitriptyline, Elavil, imipramine, Tofranil	**10 days**
Doxepin, Sinequan, Pamelor, nortriptyline	**10 days**
Xolair	**7 days**

If you are taking medications with antihistamine effects, which cannot be stopped because of the severity of your condition, continue taking the prescription and let the office know prior to your visit.

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65 Lafayette Road, 2nd Floor
North Hampton, NH 03862
Phone: (603) 964-3392 Fax: (603) 964-3396

PATIENT NAME: _____ DOB: _____

Requesting physician: _____

What are the problems that bring you to this practice? _____

_____

_____

_____

CURRENT SYMPTOMS: **Do you have?** (Circle all appropriate answers.)

Eye Symptoms: none, itching, watering, redness, swelling, crusting, dryness, burning, dark circles, blurred vision, other _____

Ear Symptoms: none, itching, popping, congested, frequent infections, fluid in middle ear, blocked, hearing loss, earache, dizziness, other _____

Nasal Symptoms: none, sneezing, itching, sniffles, watery discharge, cloudy discharge, congestion, nosebleeds, loss of sense of smell/taste, polyps, frequent sinus infections, nasal dryness, snoring at night, other _____

Mouth and Throat Symptoms: none, sore throat, hoarseness, itchy throat, difficulty swallowing, swollen neck glands, mouth breathing, frequent strep throat, frequent tonsillitis, postnasal drip, bad breath/foul taste, other _____

Sleep History and Symptoms: none, weight gain within last 12 months_____ lb, snoring, grunting, witnessed stop breathing, restless night sleep, daytime sleepiness, poor memory and concentration, could fall asleep while driving, other _____

Headaches: none, infrequent, occasional, frequent, occur with sinus symptoms, sharp, dull, pounding, facial, forehead, temples, back of head, migraine, other _____

Chest Symptoms: none, chronic cough, chest tightness/congestion, wheezing, shortness of breath at rest/on exertion, wheeze/ cough after exercise, sputum production, chest pain or pressure, heart murmur, sudden onset of difficulty breathing, coughed up blood, swollen legs, blue lips or fingernails, leg cramps when you walk, other _____

Stomach/Intestinal Symptoms: none, nausea and vomiting, bloating, loss of appetite, abdominal pain or cramping, diarrhea frequently, constipation frequently, pain or difficulty swallowing, heartburn or indigestion, queasy stomach, acid/bitter taste, cough upon lying down, other _____

Skin Symptoms: none, dry skin, hives, swelling, itchy skin, eczema, poison ivy/oak allergy, skin sensitivity to metals, chemicals, cosmetics, other _____

Insect Sting Reaction: none, large swelling, hives, difficulty breathing, throat swelling, dizzy, other _____
Stung by: bee, fire ant, yellow jacket, wasp, hornet, other _____

Which of the following do you think cause or make your symptoms worse? (Please check appropriate boxes.)

Trigger	Nose/Sinus Eyes/Ears Symptoms	Asthma/ Shortness of Breath Symptoms	Hives/ Eczema Symptoms	Stomach/ Intestinal Symptoms	Other
Parks/fields	☐	☐	☐	☐	☐
Mowed grass	☐	☐	☐	☐	☐
Gardening	☐	☐	☐	☐	☐
House dust	☐	☐	☐	☐	☐
Weather changes	☐	☐	☐	☐	☐
Windy days	☐	☐	☐	☐	☐
Humid days	☐	☐	☐	☐	☐
Hot days	☐	☐	☐	☐	☐
Cold days	☐	☐	☐	☐	☐
Air conditioning	☐	☐	☐	☐	☐
Forced air/heat	☐	☐	☐	☐	☐
Drafts	☐	☐	☐	☐	☐
Tobacco smoke	☐	☐	☐	☐	☐
Fumes/aerosols/sprays	☐	☐	☐	☐	☐
Cosmetics/perfumes	☐	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐	☐
Soap powder	☐	☐	☐	☐	☐
Newspaper print	☐	☐	☐	☐	☐
Pets/animal exposure (list)	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Tension/excitement	☐	☐	☐	☐	☐
Clothing/fabrics	☐	☐	☐	☐	☐
Medicines (which)	☐	☐	☐	☐	☐
Milk/dairy products	☐	☐	☐	☐	☐
Beer/wines	☐	☐	☐	☐	☐
Certain foods (list)	☐	☐	☐	☐	☐
Menstrual periods	☐	☐	☐	☐	☐
URIs	☐	☐	☐	☐	☐
Other(s)	☐	☐	☐	☐	☐

Comments/explanation: _____

_____

_____

_____

Insect stings:

	Yes	No
Do you have problems with insect stings?	○	○
Local swelling	○	○
Tongue or lip swelling	○	○
Scattered hives	○	○
Shortness of breath	○	○

Have you ever been treated in an emergency room for an insect sting? ☐Yes ☐No If so, describe: _____

_____

Food allergies/sensitivities: Do you have problems with any food ingestants? If yes, describe problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs		Fish	
Wheat		Melon	
Milk		Fruit	
Cheese		Walnuts	
Crab		Peanuts	
Lobster		Tomatoes	
Shrimp		Other	

Drug allergies/sensitivities: Please list all medications that you have had an adverse reaction to and a description of that reaction.

Medication Name	**Type of Reaction**

Immunizations:

	Yes	No	DATE
DTP	◯	◯	
Hepatitis	◯	◯	
Tetanus	◯	◯	
Pneumovax/Prevnar 13	◯	◯	
Shingles vaccine	◯	◯	
Chicken pox	◯	◯	

PAST ILLNESSES: (Please check all illnesses you have had.)

- ☐ Rh fever
- ☐ Scarlet Fever
- ☐ Lyme Disease
- ☐ Migraine HA
- ☐ Hypertension
- ☐ Diabetes Mellitus: Type 2
- ☐ Hyperlipidemia
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Thyroid: Hypo
- ☐ Arthritis: Other _____ (If other, please specify)
- ☐ Gout
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Raynaud's
- ☐ Lupus (SLE)
- ☐ Pulmonary Emboli
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Pneumovax/Date Given: _____
- ☐ Seasonal Allergies
- ☐ Nasal Polyps
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Exercise-induced Asthma Chronic
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Asbestosis
- ☐ Tuberculosis or Positive Skin Test
- ☐ Lung Cancer
- ☐ Arrhythmia/palpitations
- ☐ Murmur
- ☐ Atrial Fibrillation
- ☐ Valvular Heart Disease
- ☐ Congestive Heart Failure
- ☐ Angina/Coronary Artery Disease/ Myocardial Infarction
- ☐ Atherosclerotic Peripheral Vascular Disease
- ☐ Hiatal Hernia/ Gastroesophageal Reflux Disease
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Inflammatory Bowel Disease
- ☐ Lactose Intolerant
- ☐ Irritable Bowel Syndrome
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Gallbladder Disease
- ☐ Mononucleosis
- ☐ Nephritis
- ☐ Urinary Tract Infection
- ☐ Kidney Stones
- ☐ Benign Prostatic Hypertrophy
- ☐ Prostate Cancer

Past Illnesses continued:

- ☐ Polycystic ovaries
- ☐ Ovarian cancer
- ☐ Pelvic inflammatory disease/ sexually transmitted disease
- ☐ Endometriosis
- ☐ Uterine fibroids
- ☐ Osteoporosis/osteopenia
- ☐ Uterine cancer
- ☐ Cervical cancer
- ☐ Breast cysts
- ☐ Breast cancer
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ HIV
- ☐ Eczema
- ☐ Atopic dermatitis
- ☐ Seborrhea
- ☐ Shingles
- ☐ Psoriasis
- ☐ Hives
- ☐ Cradle cap
- ☐ Skin cancer/type: _____
- ☐ Seizure
- ☐ Stroke
- ☐ Carpal tunnel
- ☐ Nerve damage
- ☐ Mental illness
- ☐ Depression
- ☐ Anxiety/neurosis
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Attention deficit disorder or attention deficit/hyperactivity
- ☐ Other

Hospitalizations (nonsurgical): Please list. _____

Surgeries: Please list. _____

Injuries: Please list. _____

Medications: Please list all medications that you are currently taking, dosage, frequency, and for what condition.

MEDICATION NAME/DOSAGE	FREQUENCY	FOR WHAT CONDITION

FAMILY HISTORY:

Family Member	Sex	Age	Alive/ Deceased	Medical Problems (List all.)
Mother	F		Deceased	
Father	M		Deceased	
Siblings			Deceased	
			Deceased	
			Deceased	
			Deceased	
Children			Deceased	
			Deceased	
			Deceased	
			Deceased	

SOCIAL HISTORY:

(◯) Single (◯) Married (◯) Divorced (◯) Widowed (◯) In a relationship

Occupation(s) of patient: _____

Occupation(s) of spouse/sig. other: _____

Occupation(s) of mother: _____

Occupation(s) of father: _____

Does patient drink alcoholic beverages? (◯) Yes (◯) No Type: _____
Frequency: _____

Cigarette use: ◯Yes/No◯ Age began: _____ Age quit: _____ Peak amount: _____ Average: _____

If you still smoke, do you want to stop? (◯) Yes (◯) No

Does anyone in the home smoke? (◯) Yes (◯) No
(◯) pipe (◯) cigarette (◯) cigar How much? _____

Caffeine consumption? (◯) Yes (◯) No Coffee/tea/soda? How much? _____

Hobbies: _____

Exercise: _____

Environment:
How long have you lived in New England? _____
Prior state(s)? _____

Location of home (◯) Rural (◯) Suburb (◯) City

Type of home (◯) Apartment (◯) Frame house (◯) Brick (◯) Condo (◯) Mobile home

Heating/AC System
(◯) Forced air (◯) Steam (◯) Radiant heat
(◯) Forced hot water (◯) Electric (◯) Woodstove/pellet
(◯) Air conditioning (window/central) (◯) Air purifier (◯) Fireplace: gas/wood

How old is dwelling: _____ How long lived there? _____

Basement (◯) Yes (◯) No What is basement used for? _____
Is basement (◯) Dry (◯) Damp (◯) Finished
Dehumidifier (◯) Yes (◯) No
Humidifier (◯) Yes (◯) No

Animals:

Do you have any pets? List. _____
How long have these pets been with you? _____
Does the animal have full range of the house? _____
Does the animal sleep on the patient's bed? _____
Does animal exposure make symptoms worse? _____

Patient's bedroom:

Floor Covering		Walls		Window Coverings	
Carpeting w/pad	◯	Wallpaper	◯	Washable curtains	◯
Carpeting w/o pad	◯	Pictures	◯	Non-washable curtains	◯
Rug w/pad	◯	Pennants	◯	Blinds	◯
Rug w/o pad	◯	Tapestries	◯	Other _____	◯
Throw rug	◯	Other _____	◯		
Linoleum	◯				
Hardwood	◯				
Other _____	◯				

Closet		Pillow		Mattress	
None	◯	Age _____ years		Age _____ years	
Door kept open	◯	Type:		Type:	
Door kept closed	◯	Feather	◯	Innerspring cotton	◯
Used for storage	◯	Foam rubber	◯	Foam rubber	◯
Seasonal clothes	◯	Synthetic	◯	Other _____	◯
		Hypoallergenic cover	◯	Hypoallergenic cover	◯

Any houseplants in bedroom? _____ Upholstered furniture? _____

What is bedding made of? (Down comforters, wool blankets, quilts, etc.) _____

Travel:
Do you feel better when traveling outside of New England? ◯ Yes ◯ No

REVIEW OF SYMPTOMS AND SYSTEMS: (Please circle all symptoms you have.)

Constitutional: Lack of energy, daytime sleepiness, trouble sleeping, snoring, loss of appetite, weight changes, fevers, fatigue, chills, night sweats.

Headaches: Forehead, temples, back of head, top of head, behind eyes, facial.

Eyes: Eye problems, such as double or blurred vision, loss of vision, glaucoma, cataracts, wears contact lenses, glasses, dentures.

Ears: Hearing problems, buzzing/ringing in ears, hearing aids.

Nose: Sinus infections, broken nose, nosebleeds, loss of smell/taste.

Mouth and Throat: Sore, itchy, difficulty in swallowing, swelling of lips or tongue, swollen neck glands.

Respiratory System: Shortness of breath, wheezing, coughing.

Cardiovascular System: High blood pressure, palpitations/arrhythmia, chest pain/tightness.

Gastrointestinal System: Change in bowel habits, choking on food, bloody or tarry stools, jaundice, abdominal pain, nausea or vomiting, diarrhea, constipation.

Renal/Reproductive: Frequency, infections, stones, bladder.

Men: Prostate problems, nighttime urination.

Women: Abnormal menstrual periods, pregnant.

If you are a woman are you past/peri-menopause ◯Yes/No◯ If so, at what age? _____

Do you take estrogen replacement/birth control pills? ◯Yes/No◯

Endocrine: Thyroid disorder, diabetes, excess thirst, hunger or urination.

Hematology: Bleeding, easy bruising, anemia.

Immune System: Frequent infections, risk factors for HIV, cancer.

Musculoskeletal System: Joint pain, swelling or redness, arthritis, back pain. Muscle aches or tenderness, gout, weakness, tremors.

Skin: Rash, itching or other skin problems.

Neurological: Paralysis (even temporary), seizures, stroke, numbness, loss of balance, history of falls, loss of memory, headaches, loss of consciousness.

Psychiatric: Unusual thoughts, nervousness, crying or sadness, depression, anxiety.