26732 Crown Valley Pkwy # 431
Mission Viejo, CA 92691
(949) 364-3551
(949) 364-1921

ALLERGY & ASTHMA MEDICAL CENTER

GEETA Venkat. M.D. , F.A.A.A.I.

Instructions for Skin Testing

You have been scheduled for the first or second part of your allergy evaluation. You will be skin tested with various allergens on your back or arms. Please follow these instructions, so we can make this more comfortable for you.

1. Diet – You may eat your normal diet.

2. Ladies - If you have long hair, you will need to pull your hair back before testing. Gentlemen - If you have hair on your back, please make sure that it is removed before coming to your testing appointment.

3. Medication - Please discontinue all antihistamines as they will inhibit the results of the allergy tests.

4. Please do not use any lotion or oil on your arms or back on the day of the testing.

Please inform us if you are taking Beta Blockers, high blood pressure medication or has a heart condition

Please discontinue the following medications for **72 hours (3 days)** prior to your testing appointment:

Ah Chew	**Chlor- Trimeton**	**Nyquil**	**Tavist D**
Allerest	**Claritin**	**Phenergan**	**Triaminic**
Allegra	**Claritin D**	**Rynatan**	**Tylenol Sinus or PM**
Benadryl	**Dimetapp**	**Seldane**	
Bromfed	**Duratapp**		

All non-prescription cold medicines with antihistimines

Hismanal must be discontinued 1 month prior to testing.

Atarax and **Zyrtec** must be discontinued 1 week prior to testing.

Please Give Our Office 24 Hours Notice If You Are Unable to Keep Your Appointment.

Feel free to call if you have any questions: (949) 364-3551

Thank you.

Dr. Geeta Venkat

26732 CROWN VALLEY PARKWAY, SUITE 431
MISSION VIEJO, CA 92691
TEL (949) 364-3551
FAX (949) 364-1921
GEETA VENKAT, M.D., F.A.A.A.I.

ALLERGY AND ASTHMA MEDICAL CENTER

PATIENT INFORMATION

Today's Date_____

Patient Name_____ Date of Birth_____ Age_____ M/F Married / Single

Mailing Address_____ Home Phone_____ SS#_____

City_____ State_____ Zip_____ Work Phone_____ Cell_____

Employer/Occupation_____

Person Financially Responsible_____ Relationship_____

Address (if different from patient)_____

Phone #_____

Employer of Responsible Party_____

In case of emergency, contact_____ Relationship_____

Phone #_____

Your Primary Doctor Name, Address_____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I full understand that I am responsible for all deductibles and/or copays at the time of service.

INSURANCE INFORMATION (Must be complete)

1st Insurance Co. & Address_____ Effective Date_____

_____

Policy Holder's Name_____

Birthdate of Policy Holder_____ SS# of Policy Holder_____

Employed By_____ ID#_____ Group#_____

Patient's Relationship to Policy Holder: Self Spouse Child Dependent

2nd Insurance Co. & Address_____ Effective Date_____

_____

Policy Holder's Name_____

Patient's Relationship to Policy Holder: Self Spouse Child Dependent

Birthdate of Policy Holder_____ SS# of Policy Holder_____

Employed By_____ ID#_____ Group#_____

I authorize the insurance company to pay directly to Geeta Venkat, M.D. I authorize Geeta Venkat, M.D., to release to the insurance company any information acquired in the course of my examination or treatment.

I authorize Dr. Venkat and her associates to treat me, and/or my minor child.

_____
(Please Sign)

ALLERGY AND ASTHMA MEDICAL CENTER
GEETA VENKAT M.D. F.A.A.A.I.
26732 CROWN VALLEY PKWY, MISSION VIEJO,CA, 92691. PH-949-364-3551

INSURANCE COVERAGE POLICY

TO ACCOMADATE OUR PATIENTS WE HAVE ENROLLED IN NUMEROUS HEALTH PLANS.WITH YOUR COOPERATION, AND OUR ASSISTANCE YOU SHOULD BE ABLE TO RECEIVE ALL THE INSURANCE BENEFITS THAT YOU ARE ENTITLED .EACH PLAN HAS ITS OWN RESTRICTIONS REGARDING WHERE AND HOW OFTEN SERVICES MAY BE RENDERED. IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR PLAN, AND INFORM US OF ANY SPECIAL REQUIREMENTS.NOT DOING SO MAY RESULT IN UNCOVERED SERVICES.PAYMENT FOR THESE SERVICES WOULD BE YOUR RESPOSIBILITY.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO ACCEPT RESPONSIBILITY AS DIRECTED.

SIGNATURE OF INSURED OR GUARDIAN _____ DATE;

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

PATIENT RECORD OF DISCLOSURES

GEETA VENKAT, M.D., F.A.A.A.I.

Allergy and Asthma Medical Center
26732 Crown Valley Pkwy., Ste. 431
Mission Viejo, CA 92691
Telephone: (949) 364-3551
Fax: (949) 364-1921

NAME	☐ F ☐ M	BIRTHDATE	PAGE

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other _____

_____
Patient Signature

_____
Date

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

#17089/37089 – Medical Arts Press® 1-800-328-2179

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PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____ Sex _____ S. M. LTP. W. D.

Address _____ Tel. No. _____

Insurance Co. _____ ☐HMO Copay $ _____ ☐PPO Copay $ _____ Referred By _____ Occupation _____

Mail Claim To _____ Policy No. _____

Instructions: Put ☑ In Those Boxes Applicable To You And In The "Yes" Or "No" Space. If Lines Are Provided Write In Your Answer.

Family History

	Father	Mother	Brother 1	Brother 2	Brother 3	Brother 4	Sister 1	Sister 2	Sister 3	Sister 4	Spouse/ Partner	Children 1	Children 2	Children 3	Children 4	Children 5	Children 6
Age (if Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (At Death)																	
Cause Of Death																	

Personal History

Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes
☐Scarlet Fever			Jaundice			☐Broken Bones ☐Cracked Bones		
Diphtheria			Epilepsy			Recurrent Dislocations		
Smallpox			Migraine Headaches			☐Concussion ☐Head Injury		
Pneumonia			Tuberculosis			Ever Been Knocked Unconscious		
Pleurisy			Diabetes			☐Food ☐Chemical ☐Drug Poisoning		
☐Rheumatic Fever ☐Heart Disease			Cancer			Explain		
☐Arthritis ☐Rheumatism			Colonoscopy / Sigmoidoscopy			Latex Sensitivity		
☐Bone Disease ☐Joint Disease			☐High ☐Low Blood Pressure			Chronic Fatigue Syndrome		
☐Neuritis ☐Neuralgia			Nervous Breakdown			Any Other Disease		
☐Bursitis ☐Sciatica ☐Lumbago			☐Hay Fever ☐Asthma			Explain		
☐Polio ☐Meningitis			☐Hives ☐Eczema					
☐Gonorrhea ☐Syphilis ☐HIV			Frequent ☐Colds ☐Sore Throat			Weight: Now One Yr. Ago		
Anemia			Frequent ☐Infections ☐Boils			Maximum When		

Allergies

Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes
☐Penicillin ☐Sulfa Drugs			Any Other Drugs			Any Foods		
☐Aspirin ☐Codeine ☐Morphine			Explain			Explain		
☐Mycins ☐Other Antibiotics			Iodine Or Radiologic Dye					
☐Tetanus ☐Antitoxin ☐Serums			Adhesive Tape			☐Nail Polish ☐Other Cosmetics		

Surgery

Have You Had Removed . . .	No	Yes	Have You Had Removed . . .	No	Yes	Have You . . .	No	Yes
Tonsils			☐Ovary ☐Ovaries			Had Hernia Repaired		
Appendix			Hemorrhoids			Had Any Other Operations		
Gall Bladder			Ever Have A Transfusion			Been Hospitalized For Any Illness		
Uterus			☐Blood ☐Plasma			Explain		

X-Rays

Ever Have X-rays Of . . .	No	Yes	Date	Disease Present
Chest				
☐Stomach ☐Colon				
Gall Bladder				
Extremities				
Back				
Mammogram				
Sigmoidoscopy / Barium Enema				
Other				

Review Of Systems

Do You Now Have Or Have You Ever Had . . .	No	Yes	Do You Now Have Or Have You Ever Had . . .	No	Yes
☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight			Kidney ☐ Disease ☐ Stones		
☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing			Bladder Disease		
Any Trouble With ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat			Blood In Urine		
Fainting Spells			☐ Protein ☐ Sugar ☐ Pus ☐ Other In Urine		
Convulsions			Difficulty In Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches: ☐ Frequent ☐ Severe			Prostate Trouble		
Enlarged Glands			☐ Stomach Trouble ☐ Ulcer		
Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged			Indigestion		
Enlarged Goiter			☐ Gas ☐ Belching		
Skin Disease			Appendicitis		
Cough: ☐ Frequent ☐ Chronic			☐ Liver Disease ☐ Gall Bladder Disease		
☐ Chest Pain ☐ Angina Pectoris			☐ Colitis ☐ Other Bowel Disease		
Spitting Up Blood			☐ Hemorrhoids ☐ Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness Of Breath ☐ Exertion ☐ At Night			☐ Constipation ☐ Diarrhea		
☐ Palpitation ☐ Fluttering Heart			☐ Parasites ☐ Worms		
Swelling Of ☐ Hands ☐ Feet ☐ Ankles			☐ Any Change In Appetite ☐ Eating Habits		
Varicose Veins			☐ Any Change In Bowel Action ☐ Stools		
Extreme ☐ Tiredness ☐ Weakness			Explain		

Immunization - EKG

Have You Had . . .	No	Yes	Have You Had . . .	No	Yes
Smallpox Vaccination (Within Last 7 Years)			Polio Shots (Within Last 2 Years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram When		
Hepatitis Vaccination					

Social History

Do You . . .	No	Yes	Do You Use . . .	Never	Occ.	Freq.	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours Sleep (Per Night)			Sleeping Pills				
Have Regular Bowel Movements			Aspirins				
Sex - Entirely Satisfactory			Cortisone				
Like Your Work (Hours Per Day) ☐ Indoors ☐ Outdoors			Alcoholic Beverages				
Watch Television (Hours Per Day)			Tobacco: Cigarettes (Pks Per Day)				
Read (Hours Per Day)			☐ Cigars ☐ Pipe ☐ Chewing Tobacco				
Have A Vacation (Weeks Per Year)			☐ Snuff				
Have You Ever Been Treated For Alcoholism			☐ Other Drugs				
Have You Ever Been Treated For Drug Abuse			Appetite Depressants				
Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week?			Thyroid Medication: ☐ No ☐ Yes, In Past ☐ None Now Now On Gr. Daily Have You Ever Taken: ☐ Insulin ☐ Tablets For Diabetes ☐ Hormone Shots ☐ Tablets ☐ No				

Women Only

Menstrual History . . .	No	Yes		No	Yes
Age At Onset			Are You Regular: ☐ Heavy ☐ Medium ☐ Light		
Usual Duration Of Period Days			Do You Have ☐ Tension ☐ Depression Before Period		
Cycle (Start To Start) Days			Do You Have ☐ Cramps ☐ Pain With Period		
Date Of Last Period			Do You Have Hot Flashes		
Pregnancies . . .	**No**	**Yes**		**No**	**Yes**
Children Born Alive (How Many)			Still Born (How Many)		
Cesarean Sections (How Many)			Miscarriages (How Many)		
Prematures (How Many)			Any Complications		

Emotions

Are You Often . . .	No	Yes	Are You Often . . .	No	Yes
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

Respiratory Assessment Questionnaire

Please answer all of the questions. This information is helpful in evaluating your medical condition.

Patient:_____ Date:_____

Yes No **1. History of Coughing**

☐ ☐ a. I wake up in the morning with a cough.

b. How often?
Check one if previous answer was Yes.
☐ Every morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

☐ ☐ c. I cough throughout the day.

☐ ☐ d. I cough frequently in the morning.

☐ ☐ e. I am awakened at night by coughing.

f. How often?
Check one if previous answer was Yes.
☐ Every night or early morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

2. History of Wheezing

☐ ☐ a. I wheeze or feel chest tightness when I awaken in the morning.

b. How often?
Check one if previous answer was Yes.
☐ Every morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

☐ ☐ c. I am awakened at night by wheezing.

d. How often?
Check one if previous answer was Yes.
☐ Every night or early morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

☐ ☐ e. I use an inhaler or nebulizer to relieve night-time or early morning symptoms.

f. How often?
Check one if previous answer was Yes.
☐ Every morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

Yes No

☐ ☐ g. I wheeze during exercise.

☐ ☐ h. I wheeze following exercise.

☐ ☐ i. I wheeze when I have a common cold.

☐ ☐ j. I wheeze during a particular time of year (Spring, Fall).

3. Congestion

☐ ☐ a. I have mucus in my chest or throat when I cough.

b. How often?
Check one if previous answer was Yes.
☐ I experience chest congestion occasionally.
☐ I feel chest congestion most mornings.
☐ I feel chest congestion most afternoons.
☐ I have chest congestion most evenings.

4. Shortness of Breath

☐ ☐ a. I feel short of breath when I awaken in the morning.

b. How often?
Check one if previous answer was Yes.
☐ Every morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

☐ ☐ c. I am awakened at night by shortness of breath.

d. How often?
Check one if previous answer was Yes.
☐ Every night or early morning.
☐ 3 or more times a week.
☐ Once a week.
☐ Once a month.

☐ ☐ e. I feel short of breath while resting.

☐ ☐ f. I feel short of breath during strenuous exercise, such as jogging or playing tennis.

☐ ☐ g. I feel short of breath during moderate exercise, such as mowing the lawn or raking leaves.

Yes No 5. Smoking History

☐ ☐ a. I smoke cigarettes, cigars or pipe.
(If answer was No, go to question 5d.)

b. For how long?
Check one if previous answer was Yes.
- ☐ I have smoked for less than one year.
- ☐ I have smoked for 1–5 years.
- ☐ I have smoked for 5–10 years.
- ☐ I have smoked for more than 10 years.

c. How much?
Check one if previous answer was Yes.
- ☐ I currently smoke less than a pack a day.
- ☐ I currently smoke 1–2 packs a day.
- ☐ I currently smoke more than 2 packs a day.
- ☐ I smoke less than 5 cigars a day.
- ☐ I smoke more than 5 cigars a day.
- ☐ I smoke less than 5 pipe-bowlfuls a day.
- ☐ I smoke more than 5 pipe-bowlfuls a day.

☐ ☐ d. I have quit smoking.

e. For how long?
Check one if previous answer was Yes; also answer "NOTE."
- ☐ I quit smoking within last 12 months.
- ☐ I quit smoking over 12 months ago.
- ☐ I quit smoking over two years ago.
- ☐ I quite smoking over five years ago.

NOTE: I previously smoked _____ years.

Yes No 6. Exposure to Dust and Fumes

☐ ☐ a. Work exposes me to asbestos dust.

☐ ☐ b. Work exposes me to cotton dust.

☐ ☐ c. Work exposes me to mining dust.

☐ ☐ d. Work exposes me to other dust (list):

_____

_____

☐ ☐ e. Work exposes me to paint fumes.

☐ ☐ f. Work exposes me to solvent fumes.

☐ ☐ g. Work exposes me to fumes from plastics.

☐ ☐ h. Work exposes me to engine exhaust fumes.

☐ ☐ i. Work exposes me to other fumes (list):

_____

_____

I am taking the following medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____