TEXAS REGIONAL ASTHMA AND ALLERGY CENTER, L.L.P.

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders

RICHARD A. MAYSE, M.D., RENE ALBERT LEON, M.D., ALI SHAKOURI, M.D., SHARON SETH, M.D.

900 East Southlake Blvd. Suite 300 Southlake Texas 76092

(817) 421-0770 (Main) (817) 421-4759 or (817) 424-8431 (Fax)

WEBSITE: www.traac.org

Dr. Shakouri-New Patient History Form
(17 & older)

Please read carefully and complete this questionnaire. Accuracy and thoroughness are essential. Please type or print answers legibly. Print this form and bring it to your new patient appointment for the physician to review with you during your visit. Check the box for the answer that pertains to your question.

Patient Name: _____ Age: _____ DOB: _____

Sex: Male ___ Female ___ Married: ___ or Single: ____

Primary Race (please select from list below):

- o African American
- o American Indian or Alaskan Native
- o Asian
- o Caucasian
- o Hispanic
- o Native Hawaiian or other Pacific Islander

Secondary Race (if applicable, please select from list below):

- o African American
- o American Indian or Alaskan Native
- o Asian
- o Caucasian
- o Hispanic
- o Native Hawaiian or other Pacific Islander

How long have you lived in North Texas? _____

Parent Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street: _____

City: _____ Zip Code: _____

Name of patient's regular or referring physician: _____

Physician's Address: _____

Physician's Phone: _____

Who referred you to our clinic? _____

Patient Name: _____ DOB: _____

Reason for your visit to the specialist?

___ Allergies: ___Seasonal ___ All Year
___Asthma ___Cough ___Sinusitis ___Hives ___Rash ___Eczema ___Food Allergy ___Insect Allergy
___ Drug Allergy ___Eye Allergy ___Recurrent Infections
___ Others:

How long have you suffered from this problem? _____

Past Medical History:

___Migraines ___Stroke ___Diabetes ___Hypertension ___Heart Disease ___Emphysema ___Ulcers
___Liver Disease ___Kidney Disease ___TB ___High Cholesterol ___Thyroid Disease ___Cancer
___AIDS/HIV ___Arthritis ___Lupus ___Immune Deficiency ___IBS ___Sleep Apnea ___Glaucoma
___Cataracts ___Acid Reflux ___Hepatitis ___Osteoporosis/Osteopenia ___Epilepsy ___Pneumonia
___Croup ___Bronchitis ___Vocal Cord Dysfunction ___RSV ___Prostate Disease ___Hiatal Hernia
___Depression ___Anxiety
___Others:

Past Surgical History:

___Tonsils ___Adenoids ___Ear Tubes ___Thyroid ___Gallbladder ___Appendectomy ___Splenectomy
___Nasal Polyps ___Sinus Surgery ___Nasal Septum Repair ___Heart Surgery ___Tubal Ligation
___Hysterectomy ___Back
___ Others:

Patient Name: _____ DOB: _____

Drug Allergy- Please list all dates and reactions below:

1. _____
2. _____
3. _____

___ None

Insect Allergy:
___ Bees ___ Fire Ants

Please list the date(s) and approximate age at which your reaction(s) occurred as well as the nature of the reaction. Please indicate if you have had testing or injections for your reactions.

Do you carry an Epinephrine Auto-Injector (i.e.: EpiPen or AuvIQ)? ___Yes ___ No

1. _____
2. _____
3. _____

____ None

Food Allergy:
___ None ___ Milk ___Egg ___Wheat ___Soy ___Peanut ___Tree Nut ___Fish ___Shellfish
___ Others:

What is the nature of your reaction(s)?

Latex Allergy: ___ Yes ___ No
What is the nature of your reaction?

Patient Name: _____ DOB: _____

Famil History:

Disease	Mother	Father	Brother	Sister	Other
Allergies	___	___	___	___	___
Asthma	___	___	___	___	___
Food Allergy	___	___	___	___	___
Drug Allergy	___	___	___	___	___
Eczema	___	___	___	___	___
Heart Disease	___	___	___	___	___
Diabetes	___	___	___	___	___
Liver Disease	___	___	___	___	___
Thyroid	___	___	___	___	___
Cancer	___	___	___	___	___
Arthritis	___	___	___	___	___
Lupus	___	___	___	___	___
TB	___	___	___	___	___
HIV	___	___	___	___	___
Cystic Fibrosis	___	___	___	___	___
Emphysema	___	___	___	___	___
Autoimmune Disease	___	___	___	___	___

Social History:

Tobacco Use? ___ Yes ___NO
If yes, how much and how long? _____

___ I have quit. When? _____

Alcohol consumption: _____ Never _____Social _____ Several times per week
___ Other habits:

Patient Name: _____ DOB: _____

Hobbies?

Occupation?

Environmental History:

___ House ___ Apartment ___ Duplex ___ Mobile Home How old is the home? _____
___ Rural Area ___ Downtown Area ___ Suburban Area

___ Cats ___ Dogs ___ Others:

Animals sleep in bedroom? ___ Yes ___ No

Secondhand smoke exposure? ___ Yes ___ No

Carpeting in: ___ House ___ Bedroom

Ceiling fans in bedroom? ___ Yes ___ No

Water damage in house? ___ Yes ___ No

Electrostatic or HEPA Filter use? ___ Yes ___ No

Feather bedding? ___ Yes ___ No

Anti-Allergic encasement on bedding? ___ Yes ___ No

___ Gas Heating ___ Wood Burning Fireplace
___ Curtains in room ___ Blinds in room ___ Both ___ Other

Allergy Testing History: ___ No ___ Yes- Year: _____ Skin Test: ___ Blood Test: ___

Allergic To:
___ Animals ___ Dust Mite ___ Molds ___ Trees ___ Grasses ___ Weeds
___ Cockroach ___ Bees ___ Fire Ants ___ Foods

Allergy Shots? ___ Yes ___ No Were the allergy shots helpful? ___ Yes ___ No
Duration of treatment: _____
Home Injections? ___ Yes ___ No

Patient Name: _____ DOB: _____

Developmental History: (For pediatric patients only)
___ Normal Pregnancy ___ Premature ___ Vaginal ___ C-Section ___ Term
Birth Weight: _____ NICU: _____ Breast-Fed: _____ -Duration?: _____
___ Maternal Smoking ___ Normal Growth ___ Normal Development
___ Day Care-Hours/Week: _____ Age child started day care: _____

Immunization History:

Immunizations Up to Date? ___ Yes ___ No
Missing: _____

Pneumovax: ___ Yes ___ No Year: _____

Last Influenza Vaccine: Year _____

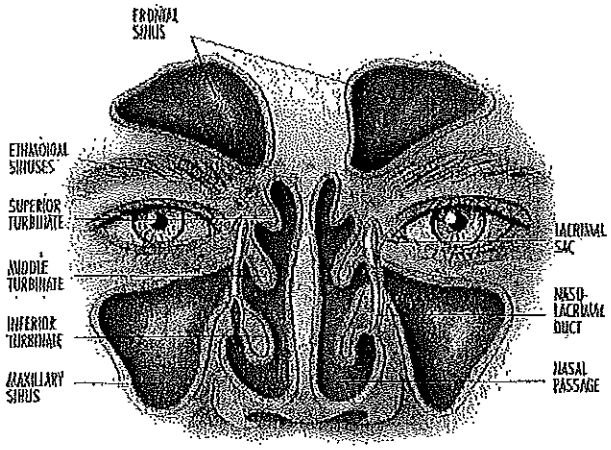
Gynecological History:
Last menstrual period: _____ Method of birth control: _____

Are you pregnant? ___ Yes ___ No
During previous pregnancies my asthma became: ___ Better ___ Worse ___ Unchanged
Are you planning on becoming pregnant in the next 6 months? ___ Yes ___ No

___ Does not pertain to me.

Allergy and Asthma Triggers:
___ Aspirin Products ___ Chemicals ___ Colds/Flu ___ Dust ___ Emotion/Stress ___ Exercise
___ Foods ___ Humidity ___ Menstrual Cycle ___ Mold ___ Ozone ___ Perfumes ___ Pets
___ Pollen ___ Seasons ___ Sinus Infections ___ Temp/Weather Changes ___ Tobacoo
___ Others:

Review of Systems:
Please circle the areas of the face where you are having problems:



Patient Name: _____ DOB: _____

Head: ___ Facial Pressure ___ Headaches

Eyes: ___Itching ___ Burning ___ Tearing ___Dryness ___ Discharge ___ Swelling

Ears: ___ Itching ___ Fullness ___ Pain ___ Popping ___ Hearing Loss ___ Frequent Infections
___ Draining (external)

Nose: ___ Itching ___ Sneezing ___ Congestion ___Snoring ___ Decreased Smell
___ Runny Nose- Type: ___ Clear ___ Colored ___ Nasal Polyps ___ Recurrent sinus infections
Most recent CT of the sinuses: _____ Normal ___ or Abnormal ___

Throat: ___ Post Nasal Drainage ___ Pain ___ Recurrent Infections ___ Foul Breath
___ Thrush ___ Itching roof of mouth

Chest: ___ Cough- Frequency: _____ ___ Wheeze- Frequency: _____
___ Nighttime cough or wheeze- Frequency: _____
___ Chest Pain/Tightness ___Shortness of Breath ___ Rest ___ During Exertion
___ Sputum Production: ___ Colored ___ Blood ___ Dry Cough
___ Recurrent Bronchitis-Frequency: _____
___ Recurrent Pneumonia-Frequency: _____
Last Chest X-Ray: _____ Normal: ___ or Abnormal: ___

Abdomen: ___ Pain- Location: _____
___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Blood in stool

Skin: ___ Eczema- Age of Onset: _____ Location: _____

___ Hives-Type: ___ Red ___ Raised ___ Itchy ___ Painful ___ Bruise ___Burn/Sting
Duration of hives in a single location: ___ Less than 24 hours ___ More than 24 hours
Are they associated with swelling?: ___ Yes ___ No
Have you had a skin biopsy?: ___ No ___ Yes- When? _____ What were the results? _____
Where? ___ Lips ___ Eyes ___ Tongue ___ Throat ___ Hands ___ Feet Other: _____

Extremities- Swelling in: ___ Hands ___ Feet ___ Legs

Miscellaneous Symptoms: ___ Fever ___ Chills ___ Fatigue ___ Night Sweats
___ Headache- Location: _____ ___ Heat/Cold Intolerance
___ Sinus Pressure ___ Bloody Nose ___ Blurred Vision ___ Swollen Neck Glands
___ Joint Pain ___ Ankle swelling ___ Loss of consciousness ___ Heart Palpitations
___ Burning during urination ___ Blood during urination
___ Weight Loss-Amount: _____

Patient Name: _____ DOB: _____

Previously Diagnosed Asthmatics Complete the Following Section

Age of Onset: _____ Symptoms are Seasonal: ___ No ___ Yes- When? _____ All Year Long?: _____
___ Hospitalized ICU? ___ Yes ___ No
Date of last ER visit: _____ Last Hospitalization: _____ Duration: _____

Frequency of my Asthma: ___ 1-2 times/week ___ 2-6 times/week ___ Daily ___ Occasional

Night Symptoms: ___ Never ___ Less than 2 times/month ___ 2-4 times/month ___ 2-4 times/week
___ Every Night

Exercise Symptoms: ___ Never ___ Sometimes ___ Always

How many days of school or work have you missed in the last 12 months because of asthma? _____

How often do you use a rescue inhaler? (i.e. Albuterol) ___ Less than 2 times/week ___ 2-4 times/week
___ 2-4 times/month ___ Daily

How often do you refill your rescue inhaler? (i.e. Albuterol) _____

When was the last time you took oral steroids? (i.e. Prednisone) _____

I Do ___ I Do Not ___ have a Peak Flow Meter. If so, my personal best measurement is: _____

Patient Name: _____ DOB: _____

Medication List (please list ALL of your current medication(s) including dose and frequency)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list prior medications for your chief complaint and if the medication was helpful or not helpful.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient Information Form

TEXAS REGIONAL ASTHMA & ALLERGY CTR

Appt Date/Time: Appt Provider: Chart #

Appt Comments:

Patient Information

First Name Middle Initial Last Name

Address Address Line 2 City State Zip Code

Email Preferred Language SSN Date of Birth

Driver's License State Primary Phone Phone Type Secondary Phone Phone Type

Gender ___ Male ___ Female

Marital Status _____

Ethnicity ___ Hispanic/Latino ___ Not Hispanic/Latino ___ Declined

Race ___ White ___ Black or African American ___ American Indian or Alaskan Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Hispanic ___ Declined

Employer Name Employer Phone

Emergency Contact Name Emergency Contact Phone Relationship to Patient

Referring Physician Primary Care Physician

Insurance Information

Primary Insurance Member # Group #

Primary Insured Name SSN Relationship Date of Birth Gender ___ Male ___ Female

Secondary Insurance Member # Group #

Primary Insured Name SSN Relationship Date of Birth Gender ___ Male ___ Female

Financial Responsibility Information

Responsible Party Name SSN Relationship to Patient Primary Phone

Address Address Line 2 City State Zip Code

Preferred Pharmacy

Pharmacy Name Pharmacy Phone Pharmacy Address

Patient/Guardian Signature

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I agree to pay for all services rendered whether or not paid by my insurance. If applicable, I agree to pay my co-payment and/or deductible & out-of-pocket at the time of service. I understand that I will be held fully responsible for any services deemed as non-covered or denied by my health insurance company.

I understand that I may make payment in the form of cash, check, or credit card (Mastercard, VISA, or Discover). I understand that my failure to make payment will result in future collection proceedings ($15 service fee will be applied). I understand that there is a $35.00 service fee on all returned checks.

I understand that I am welcome to contact the business office of Texas Regional Asthma & Allergy Center (TRAAC) to discuss any questions relating to my account.

I understand that TRAAC requires a 1 business day notification of cancellation for appointments & procedures. TRAACs policy is to charge $25.00 for no shows or late cancellations (subject to extenuating circumstances).

I certify I am 18 years of age/or the legal guardian of the patient. If I am the legal guardian/guarantor, I understand that I am financially responsible for the patient.

I assign insurance benefits and authorize treatments to be rendered by TRAAC.

I agree to release all such medical information that may be necessary to insure payment of my insurance claim(s).

I agree to notify TRAAC of any changes in my insurance status prior to treatment or I will be fully responsible for services rendered.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____

Patients Name:_____

Signature of Patient/Legal Guardian:_____

TRAAC Facsimile Authorization Form

I, the undersigned, authorize TRAAC to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving TRAAC five (5) days written notice. This revocation may be facsimile transmission: however a **written copy of the revocation must be mailed to TRAAC as well.**

Patient Name:_____

Signature of Patient or Parent of Minor: _____

Contact Information

Where can you be reached during business hours: □ Home □ Work □ Cell

May we contact you at home? □ YES □ NO
May we contact you at your place of business? □ YES □ NO

Leave Message:

Voicemail / Answering Machine □ YES □ NO
Family Member □ YES □ NO

May we contact you via email? □ YES □ NO Email address:_____
May we contact you via text message? (for appointment reminders only) □ YES □ NO

I hereby give permission to TRAAC to disclose any information related to my medical conditions to / with the following members (relatives, or close personal friends):

Name:_____ Relationship:_____
Name:_____ Relationship:_____

I do/do not wish to give permission for any family members, relatives, or close personal friends to have access to any information regarding my medical conditions:

□ I do NOT wish to give permission □ I DO give permission to the above name(s)

Signature of Patient or Parent of Minor:_____ **Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of TEXAS REGIONAL ASTHMA & ALLERGY CENTER's "Notice of Privacy Practices". This notice describes how **TEXAS REGIONAL ASTHMA AND ALLERGY CENTER** may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient or Personal Representative) (Date)

_____

(Relationship to patient)

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice:

- Rene A. Leon, M.D., Richard A. Mayse, M.D., and Ali Shakouri, M.D., are owner/investors of Methodist Southlake Hospital, in Southlake, Texas.
- You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Methodist Southlake Hospital, in Southlake, Texas.
- You will **not** be treated differently by your physician if you choose to obtain healthcare services at a facility other than Methodist Southlake Hospital, in Southlake, Texas.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Methodist Southlake Hospital, in Southlake,Texas.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and understand that your physician has an ownership interest in Methodist Southlake Hospital, in Southlake, Texas.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian
(if applicable)

Date: _____