HIGHLAND CLINIC

A Professional Medical Corporation

ADMINISTRATION
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1455 E. Bert Kouns Industrial Loop
P.O. Box 51455
Shreveport, LA 71135-1455
(318) 798-4500
www.highlandclinic.com

Patient's Name ________________________ Date of Birth ________________

Today's Date ____

All insurance's today are different as well as their coverage. To avoid unexpected charges to your account, it would be helpful for you to call your insurance company prior to your appointment to see if the below procedures are a covered benefit. The CPT codes below will assist you when talking to your insurance representative.

Please bring this sheet with you to your appointment so that we may keep this information on record for you.

Name of Insurance Company ______________________________________

Phone # ____________________ Representative Spoken With ________________

Allergy Prick Test	CPT CODE 95004	covered ______	not covered ______
Allergy Intradermal Test	CPT CODE 95024	covered ______	not covered ______
Total IgE Test	CPT CODE 82785	covered ______	not covered ______
Specific IgE Rast	CPT CODE 86003	covered ______	not covered ______
Allergen Immunotherapy	CPT CODE 95115	covered ______	not covered ______
Allergy Injections	CPT CODE 95117	covered ______	not covered ______
Allergy serum	CPT CODE 95165	covered ______	not covered ______

If for some reason this is not a covered benefit with your insurance carrier, you will need to be prepared to pay the full amount for the services rendered. The full charge amounts may range from $252.00 up to $732.00 for testing. You will need to be prepared to pay at least $300.00 with the initial visit.

Patient/Guardian
Signature ____

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WILLARD F. WASHBURNE, M.D.
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(318) 798-4544

ALLERGY HISTORY

Name:____________________
Date of Birth:____________ **Age:**______
Date of Visit:____________________

Room No. ________

Patient: Please fill out this side.

Physician Notes:

Referred By:____________________

The Reasons For Coming Here Are:

CHIEF COMPLAINTS:

- ☐ Nose Allergy
- ☐ Food Allergy
- ☐ Drug Allergy
- ☐ Insect Sting Allergy
- ☐ Contact Skin Allergy
- ☐ Skin Rash
- ☐ Eczema
- ☐ Headache
- ☐ Wheezing or Asthma
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Hives
- ☐ Itching
- ☐ Swelling
- ☐ Other:__________

Other Symptoms:

	YES	NO
Itchy or watery eyes	☐	☐
Snoring or breathing through the mouth	☐	☐
Drainage down the throat	☐	☐
Frequent yellow or green nasal drainage	☐	☐
Frequent infections	☐	☐
Headaches	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Bee sting reactions	☐	☐

Transfer of allergy care from Dr.__________
Continuation of allergy shots started _____ years ago
Diagnosis of asthma made _____ years ago
Number of past hospitalizations for asthma:_____
Number of past emergency visits for asthma:_____
Days of school or work missed in past year:_____
Number of ear infections in the past year:_____
Number of sinus infections in the past year:_____
Number of pneumonias during *lifetime*:_____

Physician Notes:

Patient's Name: ____________________

These Symptoms Occur:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ Hours at a time
- ☐ Days at a time
- ☐ Weeks at a time
- ☐ All the time
- ☐ At home - room: ____________________
- ☐ Other: ____________________

WORSE:

- ☐ Outdoors
- ☐ At work
- ☐ At school
- ☐ All day
- ☐ At night
- ☐ In Mornings
- ☐ Other: ____________________

Physician Notes:

Symptoms Are Made Worse By:

- ☐ Changes in Weather
- ☐ Changes in Temperature
- ☐ Changes in Humidity
- ☐ Fatigue
- ☐ Exercise
- ☐ Heat
- ☐ Cold
- ☐ Mowing Grass
- ☐ Raking Leaves
- ☐ Perfumes or Scents
- ☐ Dusting or Vacuuming
- ☐ Cleaning Fumes
- ☐ Cigarette Smoke
- ☐ Cats
- ☐ Dogs
- ☐ Feathers
- ☐ Wool
- ☐ Colds
- ☐ Emotions - (Anger, Laughter, Crying)
- ☐ Foods: ____________________
- ☐ Other: ____________________

Physician Notes:

Current Environment: (✓ if present)

	YES	NO		YES	NO
Cats	☐	☐	Cigarette Smoke	☐	☐
Dogs	☐	☐	Forced Air Heat	☐	☐
Birds	☐	☐	Air Conditioning	☐	☐
Other Pets	☐	☐	Fans	☐	☐
Feather Pillow	☐	☐	Mold Growth	☐	☐
Feather Comforter	☐	☐	Damp Walls or Carpet	☐	☐
Carpets or Rugs	☐	☐	Houseplants	☐	☐
Air Cleaner	☐	☐	Improvement on Trips	☐	☐

Plastic Covers on Mattress, Pillows and Box Springs ☐ ☐

Occupation: ____________________

If patient is a child, is he or she in a nursery setting? ☐ ☐

If YES, how many children are in the nursery? __________

Physician Notes:

Patient's Name: ____________________

Environmental History

Composition of House

☐ Foundation ☐ Pier/Beam ☐ Foundation and Pier/Beam

Type of Home: ☐ Apartment ☐ Mobile Home/Trailer ☐ Townhouse ☐ Brick ☐ Wood ☐ Brick/Wood

Age of Home? [ ]

Has there ever been any water damage in the home? ☐ Yes ☐ No [ ]

Does the house have carpet, if so how old? ☐ Yes ☐ No age of carpet [ ]

☐ Carpet removed

Heating/AC ☐ Gas Heat/Electric Air ☐ Central Heat/Air ☐ Window Units

---

How old is the mattress? [ ]

What type of pillow does the patient sleep on? ☐ Feather ☐ Foam

Pets: ☐ Yes ☐ No [ ]

Do any pets sleep in the bedroom, if so where? ☐ Yes ☐ No ☐ Pet sleeps in the bed ☐ Pet sleeps on the floor ☐ Pets in cages in bedroom

Hobbies: [ ]

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All Current Medicines:

number of mg. tabs, caps. or inhaler puffs

Patient's Name:____________________

Physician Notes:

Medicine	Amount	Frequency	Physician Notes
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	
		____ times per day	

Previous Allergy or Asthma Medications: (incl. OTC)

Physician Notes:

Medication					Physician Notes
	☐ 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	
	☐ helped	☐ no help	☐ drowsy	☐ jittery	
	☐ helped	☐ no help	☐ drowsy	☐ jittery	
	☐ helped	☐ no help	☐ drowsy	☐ jittery	

Past Allergy History: (use space at right if needed)

Physician Notes:

	YES	NO
Previous allergy testing	☐	☐

If YES then answer the questions below:

Testing by Dr.________________ in 19____

	YES	NO
Previous allergy shots	☐	☐
Still on allergy shots	☐	☐

Shots are received every ____ weeks now.

	YES	NO
Allergy shots have helped	☐	☐
Only minor reactions with the shots	☐	☐

If MAJOR reaction then explain:____________________

Other Comments:

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Past Medical History:

Patients Name: ____________________

Physican Notes:

Hospitalization: Age or Year

______ for ____________________
______ for ____________________
______ for ____________________
______ for ____________________

Surgeries:

______ for ____________________
______ for ____________________
______ for ____________________
______ for ____________________
______ for ____________________

Emergency Visits: ______ times in past year.
______ times in past five years.

Drug Allergies: **Symptom(s):**

__________ caused ____________________
__________ caused ____________________
__________ caused ____________________

Immunizations:

Current on Immunizations: ______ Yes ______ No
Pneumococcal 7-Valent Vaccine (Prevnar): ______ Yes ______ No
Pneumococcal 23-Polyvalent Vaccine (Pneumovax): ______ Yes ______ No
Infuenza Virus Vaccine (Fluzone): ______ Yes ______ No
Behind on Which Immunization(s): ____________________
Immunization Adverse Reactions:
__________ caused ____________________
__________ caused ____________________

Other Chronic Health Conditions: **Age or Year**

____________________ since ______
____________________ since ______

Notes: ____________________

Review of Systems:

Physician Notes:

	Past	Present
Fever	☐	☐
Weight Loss	☐	☐
Skin Problems Besides Eczema	☐	☐
Blood Count Problems (Anemia, etc.)	☐	☐
Eye Problems (explain): __________	☐	☐
Throat Infections	☐	☐
Heart Problems or High Blood Pressure	☐	☐
Stomach Upset	☐	☐
Urinary or Bladder Problems	☐	☐
Nerve or Psychiatric Problems	☐	☐
Hormone Problems (Hot Flashes, etc.)	☐	☐
Joint Swelling or Pain	☐	☐
Other: __________	☐	☐

Family History:

Patient's Name: ____________

	Allergies	Asthma	Frequent Coughing	Frequent Infections
Father:	☐	☐	☐	☐
Mother:	☐	☐	☐	☐
Brother(s):	☐	☐	☐	☐
Sister(s):	☐	☐	☐	☐
Grandfather(s):				
Paternal:	☐	☐	☐	☐
Maternal:	☐	☐	☐	☐
Grandmother(s):				
Paternal:	☐	☐	☐	☐
Maternal:	☐	☐	☐	☐
Uncle(s):				
Paternal:	☐	☐	☐	☐
Maternal:	☐	☐	☐	☐
Aunt(s):				
Paternal:	☐	☐	☐	☐
Maternal:	☐	☐	☐	☐
Cousin(s):				
Paternal:	☐	☐	☐	☐
Maternal:	☐	☐	☐	☐
Children:				
Son(s):	☐	☐	☐	☐
Daughter(s):	☐	☐	☐	☐

Other chronic family conditions such as cystic ibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc. (include relationship to the patient): ____________

Physician Notes:

Social History:

Parents of the patient are:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ One is deceased
- ☐ Both are deceased
- ☐ None of the above

Primary residence is:
- ☐ One home
- ☐ More than one home

Occupation:
- Patient: ____________
- Mother: ____________
- Father: ____________

Hobbies:
- Patient: ____________
- Mother: ____________
- Father: ____________

Level of education:
- Patient: ____________
- Mother: ____________
- Father: ____________

Do you smoke? ☐ Yes ☐ No

Do you use Alcohol? ☐ Yes ☐ No

Are you now or have you ever used an illegal drug? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Physician Notes:

Name of Person Filling Out This History Form (Please Print): ____________

Relationship if Not The Patient: ____________

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ALLERGY PHYSICAL EXAM

Name: ______________________
Date of Birth: ______________ **Age:** ______
Date of Visit: ______________________

Physical Exam: (to be filled out by nurse or medical assistant)

Weight: ____________ (%)
Blood Pressure: ____________
Height: ____________ (%)
Respiration: ____________ Pulse: ____________
Peak Flow Rate: ____________
Temperature: ____________
Initials or Signature of Nurse or Medical Assistant: ____________

Physical Exam: (to be filled out by physician)

Comments: ______________________

NORMAL ▼	ABNORMAL ▼	
___	___	General Appearance / Mental Status: ____________
___	___	Ears: ____________
___	___	Eyes: ____________
___	___	Conjunctivae: ____________
___	___	Allergic Shiners: ____________
___	___	Nose: ____________
___	___	Turbinates: ____________
___	___	Nasal Crease: ____________
___	___	Nasal Discharge: ____________
___	___	Throat: ____________
___	___	Neck: ____________
___	___	Heart: ____________
___	___	Lungs: ____________
___	___	Abdomen: ____________
___	___	Lymphatics: ____________
___	___	Skin: ____________
___	___	Extremities: ____________
___	___	Clubbing: ____________
___	___	Genitalia / Groin / Buttocks: ____________
___	___	Neurologic: ____________
___	___	Other: ____________

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Patient's Name: ______________________________

Allergy Tests or Lab Tests:

SKIN TEST: See ALLERGY SKIN TESTING SHEET

- ☐ Selected Test
- ☐ Prick Test
- ☐ Intradermal Test
- ☐ Limited Screen
- ☐ Tree Nut
- ☐ Fish
- ☐ Crustaceans
- ☐ Test To Foods
- ☐ Complete
- ☐ Limited
- ☐ Patch Test
- ☐ Test For Dermatographism
- ☐ Test For Delayed Pressure
- ☐ Test For Heat Induced Urticaria
- ☐ Test For Cold Induced Urticaria

LABS:

- ☐ IgG - 001768
- ☐ IgA - 001768
- ☐ IgM - 001768
- ☐ Immunoglobulin Subclasses - 209601 (IgG_1 IgG_2 IgG_3 IgG_4)
- ☐ IgE - 002170
- ☐ Nasal Smear For Eosinophils
- ☐ CBC With Differential - 005009
- ☐ Urinalysis - (Mid-Stream Clean Catch) - 003772
- ☐ ESR (Sed Rate) - 005215
- ☐ Pre Diptheria Titer (Hold) - 163253
- ☐ *Post* Diptheria Titer - 163253
- ☐ Pre Tetanus (Hold) - 163253
- ☐ *Post* Tetanus Titer - 163253
- ☐ Pre Pneumovax (Hold) - 138210
- ☐ *Post* Pneumovax - 138210
- ☐ Pre Prevnar - 138482
- ☐ Post Prevnar - 138482
- ☐ Hemophilus Influenza B Antibody - 138271
- ☐ Hepatitis Screen - 322744
- ☐ ANA (Antinuclear Antibody) - 006254
- ☐ Rheumatoid Factor - 006502
- ☐ RAST To: ______________________

  ____
- ☐ Strep Screen - 008169
- ☐ Strep Culture - 008169
- ☐ C4 - 001834
- ☐ C2 - 161414
- ☐ C1 Esterase Inhibitor - 004648
- ☐ C1 Esterase Inhibitor Functional Assay - 120220
- ☐ C3 - 006452
- ☐ CH50 - 001941
- ☐ C1q Binding Assay
- ☐ Complete Metabolic Panel - 322000
- ☐ Renal Function Panel - 80069
- ☐ Hepatic Function Panel - 322755
- ☐ Theophylline Level - 007336
- ☐ Sweat Test - (At LSU CF Clinic)
- ☐ Cold Agglutinin - 006353
- ☐ West Nile Virus - 138842
- ☐ Mast Cell Tryptase - 826008
- ☐ T4 - 001149
- ☐ TSH - 004259
- ☐ Thyroid Antithyroglobulin - 006692
- ☐ Thyroid Peroxidase Antibodies - 006676
- ☐ Antibody to H-Pylori - 162289
- ☐ Blood Type (ABO grouping) - 006049
- ☐ Isohemagglutinin Titer - 096164
- ☐ Other: ______________________
- ☐ Other: ______________________

X-RAYS:

- ☐ EPA & Lateral of Chest: ______________________
- ☐ Waters View of Sinus: ______________________
- ☐ CT - Scan of Sinus: ______________________
- ☐ CT - Scan of Chest: ______________________
- ☐ Other: ______________________

Patient's Name: ______________________

Spirometry:

	Before Bronchodilator	After Bronchodilator
☐ Pulmonary Function	______	______
FEV1 % Predicted	______	______
FEF 25-75 % Predicted	______	______
☐ Peak Flow Rate	______	______

Request For Release of Records:

Physician:	Address:
☐ ______________________	______________________
☐ ______________________	______________________
☐ ______________________	______________________

Assessment:

____

Plan:

____

Return Visit In:

_____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

PHYSICIAN: ______________________ **M.D. Date:** __________