

Muncie Allergy Center, P.S.C.
Sai Karlapudi, M.D. & Karen Ronald, N.P.
4505 North Wheeling Avenue Muncie, Indiana 47304
Phone (765) 284-4050 Fax (765) 284-9301
New Castle Clinic 1007 N 16th Street 47362
www.muncieallergycenter.com

Dear Patient,

_____ has an appointment _____

Thank you for choosing Muncie Allergy Center for your care. Please call us to confirm your appointment at **765.284.4050** when you receive this packet. Our office requires a 24-hour cancellation and in the event that we do not receive this notice, there will be a \$25.00 fee.

Please fill out the patient history form and bring this packet along with any insurance cards to the office the day of your appointment and be prepared to pay any co-pay required by your insurance.

Please bring a list of all medications that you are currently taking and records of previous treatments including written x-ray reports, lab, skin tests, or blood test results. Many times if you call your family doctor and ask, s/he will send a letter describing your treatment along with pertinent medical records. Your primary care physician's office can provide a Release of Information form which can be sent to other physicians or hospitals prior to your appointment.

If you will be seeing us in regard to nasal allergies, sinus trouble, and/or asthma, we may need to do allergy skin testing, which means you should not take antihistamines for 5 days prior to the scheduled appointment. Many over the counter medications that say "allergy" contain antihistamines. If in doubt ask your pharmacist. Antihistamines that will need to be stopped 5 days prior to your appointment are Allegra (fexodendaine), Allegra D, Claritin (loratadine), Claritin D, Clarinex, Clarinex D, Zyrtec, Zyrtec D, Xyzal pills & Astelin, Astepro, Patanase nasal Sprays. If you are taking blood pressure medicine, call before your appointment to speak with a nurse. Most other medications, including asthma medications, will not interfere with skin testing and should be continued. If you have a skin rash or hives, it is not necessary to stop your medication for the first visit. Please call us at 284.4050 with any questions.

Our office is located 8/10ths of a mile North of McGalliard Road on the West side of Wheeling Avenue and 2/10ths of a mile South of Riggin Road.

You are scheduled for a 2-hour appointment. Please plan on being here the full time if necessary. If the patient is a young child, it is helpful to bring along favorite toys or even a second adult to keep the child occupied for this length of time.

Thank you for your cooperation as we are making every effort to see you in a timely manner. Please visit our website listed above for directions to our Muncie and New Castle locations.

Sincerely,



Sai Karlapudi, M.D.

Sincerely,



Karen Ronald, N.P.

Please answer the following questions about yourself or your child: What is the main reason you are here today?

How long have symptoms been present? _____

The following list includes a list of symptoms. For the symptoms indicate whether they are (1)mild , (2)moderate, or (3) severe

1, 2, 3	CHEST SYMPTOMS	1, 2, 3	THROAT OR SINUSES
_____	shortness of breath	_____	sore throat
_____	tightness in chest	_____	tonsillitis
_____	wheezing	_____	bad colds
_____	coughing	_____	hoarse/laryngitis
_____	wheezing or coughing worse with exercise?	_____	sinus infections
_____	wheezing or coughing worse at night?	_____	postnasal drainage
_____	have you ever had bronchitis, pneumonia, or croup?	_____	headaches (see below)
_____	more than once?	_____	sinus surgery
_____	how many times have you been hospitalized for asthma?	_____	nasal polyps
_____	last hospitalization?	1, 2, 3	EYES
_____	last emergency room visit?	_____	watering or tearing
1, 2, 3	NASAL SYMPTOMS	_____	itching or redness
_____	stuffiness/congestion	_____	light hurts eyes
_____	itching of nose or mouth	_____	dark circles under eyes
_____	frequent sneezing	_____	puffy around eyes
_____	clear thin drainage	_____	dry or gritty eyes
_____	throat clearing	_____	thick discharge
_____	loss of smell or taste	_____	eye pain
_____	snoring/noisy sleep	1, 2, 3	EARS
_____	nose bleeds	_____	frequent infections
1, 2, 3	SKIN	_____	stopped up
_____	rashes	_____	trouble hearing
_____	eczema	_____	itching
_____	hives	_____	dizziness
_____	poison ivy	_____	pain
		_____	ringing
		_____	ear surgery (tubes)

HEADACHES

How frequent are the headaches? _____

Any other family members with headaches? _____

Are there certain times of the year or types of weather when your symptoms are worse? _____

When? _____

What other activities or exposures (hobbies, work, strong odors, etc.) can you think of that make your symptoms worse? _____

Have your symptoms been helped by any medications you have tried in the past? _____

About how many days of work or school per year do you miss from the above symptoms? _____

Have you had an adverse reaction to an insect sting and were you prescribed medications for it?
Please list below.

Have you had any allergic reactions or any type of bad reactions to medications? If so, describe. _____

Are these any foods which cause you to have rashes, cramps, swelling, or asthma? If so, describe. _____

Do you now, or did you ever smoke? _____ If yes, what and how much per day? _____

Have you stopped smoking? _____

How many years have you smoked? _____

Are you exposed to tobacco smoke at home or at work? _____

Please list all present medications.

Please include dosage, strength, and number of times a day taken. Please also include over-the-counter medications including aspirin or other pain medications, laxatives, or vitamins. _____

How many times have you taken antibiotics in the past year? _____ Can you recall the names of any of the antibiotics? _____

Have you ever received cortisone or steroids in injection or tablet form? If so, how frequently? _____

Please list all previous surgical procedures, serious accidents, or injuries with approximate dates. _____

Please list any other hospitalizations (including childbirth) and the medical diagnosis and treatments with approximate dates. _____

Are you under a doctor's care for any other medical conditions? (blood pressure, diabetes, etc.) _____

REVIEW OF SYSTEMS:

Do you now have or have you had difficulties with any of the following?

_____ Diabetes or thyroid trouble

_____ Glaucoma or other eye problems

_____ Stroke, weakness, convulsions

_____ Emphysema

_____ Swelling of feet or ankles (edema)

_____ Stomach or digestive problems

_____ Arthritis

_____ Bladder or kidneys

_____ Prostate

_____ Female problems

_____ Cancer

_____ Unexpected weight loss or gain

IF YOU HAVE ANY BLOOD RELATIVES WITH THE FOLLOWING PROBLEMS. PLEASE CHECK THE APPROPRIATE COLUMN.

	Asthma	Hayfever	Eczema	Hives	Sinus Problems
Mother					
Father					
Brother					
Sister					
Children					
Aunt					
Uncle					
Grandfather					
Grandmother					

Do any blood relatives have:

_____ Diabetes

_____ Heart disease

_____ Frequent infections

_____ Emphysema

_____ High blood pressure

_____ Cancer

PREVIOUS ALLERGY EVALUATIONS

Have you ever had an allergy evaluation in the past? _____ If yes, at what age was the allergy evaluation done? _____.

Circle the diagnosis that was made: Hayfever Asthma Eczema Sinus Other

If you were skin tested, to what were you found to be allergic?

Trees Grass Weeds Molds Dust Animals Feather Foods Other

Have you received allergy injections in the past? _____

What improvements have you noticed? _____

COMPLETE THE FOLLOWING QUESTIONS FOR CHILDREN UNDER EIGHT

Any breathing problems or other complications in the nursery? _____

Please explain _____

Breast fed? _____ How long? _____ Bottle fed? _____ Type of formula? _____

Any difficulties with formula? _____

DURING THE FIRST YEAR OF LIFE DID THE CHILD HAVE:

_____ Skin rash (other than diaper rash)

_____ More than one ear infection

_____ Nasal congestion (severe)

_____ Chest cold

_____ Wheezing

_____ Colic more than 3 months

_____ Unexplained diarrhea

ENVIRONMENTAL HISTORY

Please **circle** appropriate answers or fill in the blanks.

Neighborhood: urban suburban rural cultivated fields woods near water

House **Apartment** **Mobile Home**

Time living there _____ approximate age of dwelling _____

Basement: damp dry ever flooded finished

Crawl Space: damp dry ever flooded

Heat: forced air gas electric oil gas stove radiant heat
ceiling cable baseboard radiator wood heat kerosene
fireplace used frequently used infrequently

Air Conditioning: none central window used frequently used infrequently

Humidifier **Dehumidifier** **Fan**

Use of: potpourri air freshener other aerosols

Pets: Dog # _____ inside outside in bedroom

Cat # _____ inside outside in bedroom

Others: Including exposure to farm animals _____

Bedroom: # of beds _____ regular mattress plastic dust-proof mattress cover
water bed stuffed animals in room on bed pillows feather
foam rubber polyester all bedding (blankets, spreads, etc.)
washable? _____ old quilts down comforter "clutter"
old books upholstered furniture carpeting

Employment History: Present type of employment _____

Exposure to smoke, fumes, or other hazards _____

Daycare History (for children): Age when daycare started _____ number of other children at facility _____.

PLEASE DO NOT WRITE ON THIS PAGE

Date _____

PHYSICAL EXAMINATION

NAME _____ Ht _____ Wt _____ BP _____ PEFR _____

Eyes: Conjunctivae OK injected cobblestones lids puffy dark circles

Ears: Rt TM OK injected dull scarred amber fluid

Lt TM OK injected dull scarred amber fluid

Nose: No abnormality septum deviated straight

no mucus scant clear white yellow thick bloody

polyps Rt Lt excoriations

membranes normal pink red pale lavender

edema none slight 2+ 3+ 4+

Throat: tonsils absent or small enlarged inflamed

posterior pharynx normal inflamed lymphoid hypertrophy

postnasal drainage none clear thin yellow/green thick

Cervical glands: unremarkable shotty small nontender enlarged tender

Thyroid: unremarkable palpable

Chest:

Abdomen:

Musculoskeletal:

Skin: