

**Muncie Allergy Center, P.S.C.**  
**Sai Karlapudi, M.D. & Jordan Overholt, F.N.P.**  
4505 North Wheeling Avenue Muncie, Indiana 47304  
Phone (765) 284-4050 Fax (765) 284-9301  
New Castle Clinic 1007 N 16<sup>th</sup> Street 47362  
[www.muncieallergycenter.com](http://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.**

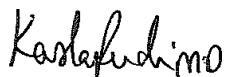
If you will be seeing us in regard to nasal allergies, sinus trouble, and/or asthma, we may need to do allergy skin testing, which means you should not take antihistamines for 5 days prior to the scheduled appointment. Many over the counter medications that say "allergy" contain antihistamines. If in 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,



**Jordan Overholt, F.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
- \_\_\_\_\_ tightness in chest
- \_\_\_\_\_ wheezing
- \_\_\_\_\_ coughing
- \_\_\_\_\_ wheezing or coughing worse with exercise?
- \_\_\_\_\_ wheezing or coughing worse at night?
- \_\_\_\_\_ have you ever had bronchitis, pneumonia, or croup?
- \_\_\_\_\_ more than once?
- \_\_\_\_\_ how many times have you been hospitalized for asthma?
- \_\_\_\_\_ last hospitalization?
- \_\_\_\_\_ last emergency room visit?

- \_\_\_\_\_ sore throat
- \_\_\_\_\_ tonsillitis
- \_\_\_\_\_ bad colds
- \_\_\_\_\_ hoarse/laryngitis
- \_\_\_\_\_ sinus infections
- \_\_\_\_\_ postnasal drainage
- \_\_\_\_\_ headaches (see below)
- \_\_\_\_\_ sinus surgery
- \_\_\_\_\_ nasal polyps

**1, 2, 3 NASAL SYMPTOMS**

- \_\_\_\_\_ stuffiness/congestion
- \_\_\_\_\_ itching of nose or mouth
- \_\_\_\_\_ frequent sneezing
- \_\_\_\_\_ clear thin drainage
- \_\_\_\_\_ throat clearing
- \_\_\_\_\_ loss of smell or taste
- \_\_\_\_\_ snoring/noisy sleep
- \_\_\_\_\_ nose bleeds

**1, 2, 3 EYES**

- \_\_\_\_\_ watering or tearing
- \_\_\_\_\_ itching or redness
- \_\_\_\_\_ light hurts eyes
- \_\_\_\_\_ dark circles under eyes
- \_\_\_\_\_ puffy around eyes
- \_\_\_\_\_ dry or gritty eyes
- \_\_\_\_\_ thick discharge
- \_\_\_\_\_ eye pain

**1, 2, 3 SKIN**

- \_\_\_\_\_ rashes
- \_\_\_\_\_ eczema
- \_\_\_\_\_ hives
- \_\_\_\_\_ poison ivy

**1, 2, 3 EARS**

- \_\_\_\_\_ frequent infections
- \_\_\_\_\_ stopped up
- \_\_\_\_\_ trouble hearing
- \_\_\_\_\_ itching
- \_\_\_\_\_ dizziness
- \_\_\_\_\_ 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: