Muncie Allergy Center, P.S.C.
Sai Karlapudi, M.D. & Claudia Fenoglio, 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, Allegra D, Claritin, Claritin D, Clarinex, Clarinex D, Zyrtec, Zyrtec D . Astelin Nasal Spray must be stopped 2 days prior to your appointment. 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, Sincerely,

Sai Karlapudi, M.D. **Claudia Fenoglio, 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 s list of symptoms. For the symptoms indicate whether they are (1)mild , (2)moderate, or (3) severe

1, 2, 3 CHEST SYMPTOMS

_____ 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?

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 SKIN

_____ rashes

_____ eczema

_____ hives

____ poison ivy

1, 2, 3 THROAT OR SINUSES

_____ sore throat

_____ tonsillitis

_____ bad colds

_____ hoarse/laryngitis

_____ sinus infections

_____ postnasal drainage

_____ headaches (see below)

_____ sinus surgery

_____ nasal polyps

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 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: