Vanderbilt Asthma Sinus and Allergy Program
p. 615.936.2727 f. 615.936.5767 toll free 1.866.390.0379
www.VanderbiltAllergy.com

New Patient Packet

Please print and complete the enclosed medical forms and bring them with you to your first appointment.

Please use Black ink only

Do not mail or email back to us.

Before your appointment, please obtain your last two clinic notes from your PCP/specialist, any pertinent lab test results and any scans/x-rays related to your condition. Please bring this data with you to your first clinic visit.

VANDERBILT HEALTH

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Welcome to the Vanderbilt Asthma, Sinus and Allergy Program. The following information will assist you with your visit. Please read and complete all enclosed medical forms.

We ask that you arrive 30 minutes before your scheduled appointment time.

Appointment day: _____
Appointment time: _____
Arrival time: _____

You are scheduled at the following ASAP site: (circle one below)

2611 West End Ave Brentwood Franklin Lebanon Gallatin

To insure best directions from your starting location; please use GPS or Mapquest.

VASAP @ 2611 West End Ave. between the Holiday Inn and J. Alexanders Redlands Grill restaurant, across the street from Centennial Park. **Parking:** Park at the rear of our building in the lot that we share with the Holiday Inn. Enter the second floor of the building by crossing the covered walkway.

VASAP @ The Shoppes at Brentwood - 782 Old Hickory Blvd., Ste 203 Brentwood, TN 37027 **Parking:** The Shoppes at Brentwood parking lot.
VASAP @ Franklin – 919 Murfreesboro Rd, Franklin, TN 37064

VASAP @ Lebanon – 1409 W Baddour Pkwy, Suite E, Lebanon, TN 37087

VASAP @ Gallatin – 300 Steam Plant Rd, Suite 460, Gallatin, TN 37066

• **What to expect:** Our team of healthcare providers will provide you with a thorough evaluation and will design an individualized education and treatment plan based on your evaluation findings. Tests that may be ordered may include allergy testing, sinus CT scans, pulmonary function tests, and/or chest x-rays. All proposed testing will be thoroughly explained and discussed with you. Should you have any questions or specific needs regarding your visit, please contact us.

• **Preparation:** To enable us to provide you with a thorough evaluation, **please allow 4 hours for your** initial visit. Due to the extensiveness of this evaluation, we ask that young children do not accompany you. Read all enclosed materials – especially note which medications need to be withheld in order to complete testing. Complete all enclosed medical forms ahead of time and bring these with you. **Please do not wear (or anyone with you) any kind of perfume, after shave or fragranced lotions.**

• **Cancellations:** While it is understood that patients' schedules can change, we do require a minimum of 24 hour notice if you cannot keep your appointment. Please call us immediately at 615-936-2727 if you need to reschedule.

VANDERBILT HEALTH

Insurance/Referral/ Payment for Services

• **Insurance/Referrals:** If your insurance requires a referral from your primary care provider for your visit with us, **YOU** must obtain this before your visit. If you do not have your referral form, you will be given the option to reschedule your visit or pay for the visit at the time the service is rendered and file with your insurance company yourself. Your PCP ore referring physician may fax these forms to us at 615-936-5767 prior to your visit. If you have questions, please call us at 615-936-2727. **Please bring your insurance card with you.**

IT IS YOUR RESPONSIBILITY TO CHECK YOUR INSURANCE FOR BENEFIT AND COVERAGE INFORMATION PRIOR TO YOUR APPOINTMENT INCLUDING CO-INSURANCE, CO-PAYMENT AND DEDUCTIBLE AMOUNTS THAT MAY BE DUE BY THE PATIENT.

You will be expected to pay for your co-pay and/or any out of pocket expense at time of service.

*** To determine what your insurance provider will cover, you may use this tool to verify benefits and coverage prior to your appointment by calling your insurance provider and providing these codes.**

TEST			INSURANCE CODE BILLED
CT scan of the Maxillofacial Sinus (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the imaging service)			**70486**
Deductible: Coinsurance: Co-Pay:	Y/N _____ Y/N _____ Y/N _____	Amount $: _____ Amount %: _____ Amount $: _____	
Allergy Skin Testing (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the allergy skin testing)			**95004 and /or 95024 and/or 95018**
Deductible: Coinsurance: Co-Pay:	Y/N _____ Y/N _____ Y/N _____	Amount $: _____ Amount %: _____ Amount $: _____	
Spirometry (breathing treatment for your lungs) (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the breathing treatments)			**94010 and /or 94060**
Deductible: Coinsurance: Co-Pay:	Y/N _____ Y/N _____ Y/N _____	Amount $: _____ Amount %: _____ Amount $: _____	

Does my insurance require a referral to a specialist? Y/N _____

Does my insurance require me to use a specific laboratory when blood test or other specimen collection for treatment is performed? Y/N _____

If yes, name of laboratory: _____

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VANDERBILT HEALTH

New Patient Checklist for Initial Clinical Visit

- □ Eat breakfast
- □ Wear comfortable clothes and shoes
- □ If this is your first visit, please plan on being at the ASAP Clinic for **a *minimum of 4 hours***
- □ Please call **Central Registration (888-567-5255 or 615-322-2971**), if you have not done so already to complete registration and verification of insurance or payment arrangement.
- □ Completed Patient Information form
- □ Completed Medication form
- □ Completed ASAP Patient Questionnaire form
- □ Bring your insurance card / information to your first appointment
- □ Provide us with your pharmacy name, address, phone and FAX numbers
- □ **Referral (if required)**
- □ Arrive 30 minutes prior to your appointment – we do our best to see patients timely, however, unforeseen events may cause delays. We do try our best to keep on schedule as much as possible
- □ Prior to visiting us on your first visit to Vanderbilt ASAP – register for *MyHealthatVanderbilt.com*. This website allows you to send emails to us regarding appointments and prescription refills. Once you have registered and visited us in the office we can update your status so you can review your lab results.
- □ Reading material or personal entertainment (iPods w/headphones, etc) to help pass the time between testing and clinic consultation with your provider

Any questions, please do not hesitate to contact us AT 615-936-2727.

Sincerely,

VANDERBILT ASTHMA SINUS ALLERGY PROGRAM (ASAP)

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PATIENT MEDICATION INSTRUCTIONS

1) Please discontinue use of antihistamines at least ***5*** days before appointment, **DO NOT** stop medications if you are taking them for hives, asthma, swelling or severe allergic reactions.

ANTIHISTAMINES:

Accuhist
Actifed
Advil Allergy Sinus
Alavert (Loratadine)
Allegra / Allegra D (Fexofenadine)
Antivert (Meclizine)
Atarax (Hydroxyzine)
Benadryl (diphenhydramine)
Brompheniramine
Chlorphenirmaine
Claritin / Claritin D (Loratadine)
Clarinex
Compazine
Deconamine
Dimetapp
Doxepin Naldecon (cyproheptadine)
Nyquil
Periactin
Phenergan (Promethazine)
Rescon
Rynatan (azatadine)
Triaminic
Tylenol Allergy Sinus
Tylenol PM
Tussi-12
Xyzal (levocetirizine)
Zyrtec / Zyrtec D (cetirizine)

NASAL SPRAY ANTIHISTAMINE
Astelin
Astepro
Patanase

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MEDICATIONS

NAME: _____ DATE: _____

YOUR PHARMACY: _____PHARMACY PHONE #_____

PLEASE LIST BELOW ALL MEDICATIONS THAT YOU CURRENTLY TAKING.

(PLEASE INCLUDE ALL PRESCRIPTION, OVER THE COUNTER AND NON-PRESCRIPTION DRUGS, INCLUDING BIRTH CONTROL PILLS, INSULIN, ASPIRIN, SINUS MEDICATIONS, HORMONES, PATCHES, OINTMENTS, INJECTIONS, NASAL SPRAYS, ETC.)

NAME OF MEDICATION	STRENGTH OR DOSE	HOW MANY PER DAY/TIMES?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ADDITIONALLY, LIST ANY MEDICATIONS THAT YOU HAVE TAKEN IN THE LAST *MONTH* FOR ANY CONDITION.

NAME OF MEDICATION	STRENGTH OR DOSE	HOW MANY PER DAY/TIMES?
1.		
2.		
3.		
4.		

MEDICATION/DRUG ALLERGIES:

Please list below any medication/drug which you cannot take due to an allergy or a side effect from taking the drug and the reaction which occurs.

Name of Medication/Drug	Type of Reaction
1.	
2.	
3.	
4.	

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ASAP QUESTIONNAIRE

PLEASE COMPLETE IN **BLACK INK**

Patient Name:_____ **Date of Birth:** ____/____/_____

What is the reason for your visit today? _____

Do you have any problems with any of the following?

	Yes	No		Yes	No
Nasal congestion	____	____	Throat clearing	____	____
Runny nose	____	____	Hoarseness	____	____
Itchy /watery eyes	____	____	Loss of sense of smell	____	____
Facial pressure/pain	____	____	Itching (skin)	____	____
Headaches	____	____	Swelling (skin)	____	____
Sinus infections	____	____	Eczema	____	____
Sneezing	____	____	Coughing	____	____
Post-nasal drainage	____	____	Shortness of breath	____	____
			Wheezing	____	____

Allergy: Please circle answers: Do you have allergies or hay fever? Yes No Don't know
Have you ever been tested for allergies? Yes No What type of testing? Skin Blood (RAST)
Did you get allergy shots? Yes No For how long?_____ Were they helpful? Yes No
Do you have any history of allergies to the following? Circle: Foods Latex Insect stings

Sinus: Do you have a history of sinus problems? Yes No Color of drainage today?_____
How many times have you been treated for a sinus infection with antibiotics in the last year?_____
Have you ever had an x-ray or CT scan if your sinuses? Yes No If yes, when and where?_____
Have you ever had sinus surgery? Yes No If yes, when and where?_____Did surgery help? Yes No

Asthma: Have you ever been diagnosed with asthma? Yes No
Have you ever been to the emergency room because of you asthma? Yes No How often?_____
Have you ever had to stay overnight in the hospital for your asthma? Yes No How often?_____

REVIEW OF SYMPTOMS: Please indicate if you have had any of the following **IN THE LAST 30 DAYS:**

	Yes	No		Yes	No
Fever	____	____	Indigestion/Heartburn	____	____
Weight change	____	____	Constipation	____	____
Fatigue	____	____	Diarrhea	____	____
Sleep problems/snoring	____	____	Trouble swallowing	____	____
Skin rashes/hives	____	____	Urinary abnormalities	____	____
Unusual bruising/bleeding	____	____	Muscle pain, aches or cramps	____	____
Heart pounding/palpitations	____	____	Joint pain	____	____
Chest pain	____	____	Depression – feeling blue	____	____
Swollen ankles	____	____	Anxiety – feeling nervous	____	____
Dizziness	____	____	Problems with hearing	____	____
Nausea/vomiting	____	____	Problems with vision	____	____

General: Have you had a chest x-ray or chest CT in the last year? Yes No Results: _____
Have you had pneumonia vaccine shot (Pneumovax)? Yes No
Do you normally get a flu shot every year? Yes No
How many times in the last year have you had to take oral or injected steroids, such as prednisone or a Medrol dose pack?_____
Are there any family disputes/situations that make your or your child's care more difficult?_____

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Patient Name:_____ **Date of Birth:** ____/____/_____

Past Medical History: Do you have or have ever had any of the following conditions?

	Yes	No		Yes	No
Hives	____	____	Bowel/Intestinal disorder	____	____
Thyroid disease	____	____	Liver condition	____	____
Diabetes/blood sugar problems	____	____	Stomach ulcer	____	____
Pneumonia	____	____	Acid reflux	____	____
Tuberculosis	____	____	Anemia/low blood	____	____
Positive TB skin test	____	____	Stroke/"mini strokes"	____	____
Frequent bronchitis	____	____	Bleeding disorder	____	____
COPD/emphysema	____	____	Cancer	____	____
Other lung condition	____	____	Neurological condition	____	____
Frequent strep throat	____	____	Seizures/epilepsy	____	____
Sleep apnea	____	____	Migraine headaches	____	____
CPAP machine	____	____	Cataracts	____	____
Heart arrhythmia/palpitations	____	____	Glaucoma	____	____
Heart problems	____	____	Arthritis	____	____
High blood pressure	____	____	Back/spine problems	____	____
High cholesterol	____	____	Osteoporosis	____	____
Hepatitis	____	____	Depression/sadness	____	____
HIV/AIDS	____	____	Panic attacks/anxiety	____	____
Kidney disease/decreased function	____	____	Other psychiatric conditions	____	____
Gynecology/female problems	____	____	Alcoholism/drug dependency	____	____
Male genital/prostate problems	____	____			

Family History:

	Parent		Sibling		Child		Grandparent	
	Mother/Father		Male/Female		Male/Female		Maternal/Paternal	
Asthma	____	____	____	____	____	____	____	____
Sinus disease	____	____	____	____	____	____	____	____
Hay fever/allergies	____	____	____	____	____	____	____	____
Cystic fibrosis	____	____	____	____	____	____	____	____
Emphysema	____	____	____	____	____	____	____	____
Thyroid disease	____	____	____	____	____	____	____	____
Heart disease	____	____	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____	____	____

Surgeries/Hospitalizations: Please list all hospitalizations and surgeries and the years these occurred:

Social History:
Occupation:_____ Hobbies:_____

Do you use/have you used tobacco products? Yes No Past Circle: Cigarettes cigars pipe snuff chew dip
How many per day? _____ How many years? _____ If you've stopped, when did you stop?_____
Have you been exposed to second hand cigarette smoke? _____ Where?_____
Do you use alcohol? Yes No Drinks per week? _____ Other drug use? Yes No
Do you have any HIV risk factors? Yes No

Environmental History:
Do you have any pets in the home? Yes No Cats Dogs Other Inside Outside Both
Do pets sleep in your bedroom? Yes No
Has there been any water leakage or water damage in your home? Yes No If yes, has this been repaired? Yes No
What type of flooring? Carpet Hardwood Tile Vinyl Other

FOR OFFICE USE: REVIEWED AND CONFIRMED WITH PATIENT BY:_____ **VISIT DATE?**_____