Massachusetts General Hospital
Founding Member, Mass General Brigham

Allergy and Immunology
Yawkey Center for Outpatient Care
55 Fruit Street, Yawkey 4B
Boston, MA 02114

Tel: 617-726-3850
Fax: 617-724-0239

Dear Patient,

A new patient appointment has been made for you at Allergy Associates, MGH

Date: _____ Day:_____Time: _____

We ask that all patients bring the following:

- Photo ID
- Insurance card
- Prescription plan card
- Completed paperwork
- Co-payment
- Insurance Referral from your Primary Care Physician, it is the patient's responsibility to obtain. Patients who are seen without a referral will be asked to sign a waiver and may be billed directly.

If you are unable to keep your appointment:

- Please notify our office at least two (2) business days prior to your scheduled office visit. This allows us to schedule other patients who are waiting for an appointment.

New patient visits:

- **Please allow ample travel time.** Please arrive **15 minutes before** the scheduled time of your appointment to be checked in. If you are **more than 15 minutes late** for your appointment, you may be asked to reschedule to a later date.

- May take as long as **3 hours** because of the time required for skin testing. Your initial examination may include a series of skin tests to identify allergens to which you are sensitive.

- **For patients scheduled for skin testing, all antihistamines should be avoided for 5 days prior to your office visit.** Common prescription antihistamines include: Allegra (fexofenadine), Clarinex (desloratadine), Astelin /Astepro (azelastine hcl) nasal spray, Patanase nasal spray, Vistaril and Atarax (hydroxyzine). There are numerous over-the-counter antihistamines like Benadryl, Chlotrimeton, Zyrtec (cetirizine), Claritin/ Alavert (loratadine), and Tylenol PM. If you are not certain whether the medication you are taking is an antihistamine, please contact us at 781-487-3838.

- If you are unable to stop taking antihistamines because of the severity of your symptoms, continue on the medication but keep your appointment. Another approach to testing will be considered by your doctor.

- Please wear a sleeveless shirt for skin testing, as test reagents will be placed on both the upper and lower parts of the arms.

- Please update your registration prior to your visit by calling 1-866-211-6588.

Please visit our website at http://www.massgeneral.org/west/ourservices/allergy.aspx.

We look forward to seeing you.

MGH Allergy and Immunology Patient Information
Please complete all forms before your appointment.

Name: _____ Date of birth ____/____/____

Providers within the Mass General Brigham system will be able to review your report.
Health care providers outside of Mass General Brigham to whom reports should be sent:

Name _____ Name _____
Specialty _____ Specialty _____
Address _____ Address _____
_____ _____
Phone _____ Phone _____

State the main reason for your visit:

_____

Any specific exposure bring on your symptoms?

_____

When are your symptoms the worst? (please circle)
Winter Spring Summer Fall Year Round
When are your symptoms the worst? (please circle)
At night Mornings Evenings At Home At Work Indoors Outdoors
Have you been tested for allergies in the past?_____ If so, what were you allergic to?_____

Home environment
Please check all the boxes that describe your environment.
How long have you lived in the New England area? _____
Have you moved recently? □ Yes □ No
How long have you been in your current home? _____
How old is your current home? _____
Do you have:
□ feather pillows □ down comforter □ wall to wall carpeting
Type of heating □ Forced hot water □ Forced hot air □ electric baseboard
Air conditioning □ none □ Central □ Window
Is there:
□ Visible mold, mildew or dampness in your home Where? _____
□ Evidence of cockroaches
□ Evidence of mice
Do you have a pet?
□ Cat(s) □ Dog(s) □ Does your cat or dog go into the bedroom?
□ other pets (list) _____

Work environment
Occupation _____
Are there any features in your work environment or previous work environment that you feel are contributing to your problem? _____

Do you have any hobbies that might be contributing to your problem?_____

Have you ever smoked?_____ Age that you started _____ Age Quit ____ packs per day___
Have you ever used smokeless tobacco? _____
Does anyone in your household smoke? _____

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Name: _____ Date of birth ____/____/____

List medications, vitamins and herbal supplements you are taking. Include all prescriptions and over the counter medications.	
drug name/dose/frequency	drug name/dose/frequency

Are you allergic to any medications?

Drug name	Symptoms	Date of Reaction

Family History

	Asthma	**Seasonal Allergies**	**Sinus Disease**	**Eczema**	**Hives**	**Swelling/ Angioedema**	**Food Allergy**	**Medication Allergy**	**Autoimmune Disease**	**Known Immune Problem**	**Frequent Infections**
mother											
father											
sister											
brother											
children											
other											

□ Adopted □ Family history unknown

Past Medical History

Please put a check the appropriate box.

Do you have any of the following?	**Yes**	**No**	**Do you have any of the following?**	**Yes**	**No**
High blood pressure			Autoimmune disease		
Diabetes			Thyroid problem		
Heart problems			Hospitalization for infection		
Liver problems			Pneumonia		
History of cancer			Sinus infections		
History of seizures			Recurrent ear infections		
Acid reflux disease			Hives		
Sinusitis			Eczema		
Nasal Polyps			Unexplained swelling		
History of sinus surgery			Reaction to insect sting		
Chronic congestion			Other: _____		

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Please complete <u>all forms</u> before your appointment.

Name: _____ Date of birth ____/____/____

Have you had any of these symptoms recently?
Please put a check the appropriate box.

General	**Yes**	**No**	**Skin**	**Yes**	**No**
Fever or chills			Rashes		
Unexpected weight change			Hives		
Enlarged lymph nodes			Dry skin		
Eyes			Sensitive skin		
Itchy watery eyes			Swelling		
Red eyes			**Gastrointestinal**		
Blurry vision			Trouble swallowing		
Pain in eyes			Diarrhea		
Ears/Nose/Throat			Abdominal pain		
Ear Pain/popping			Heartburn/reflux		
Hearing difficulty			Nausea or vomiting		
Post-nasal drip			**Endocrine**		
Runny nose			Constant thirst		
Sinus pain or pressure			Heat intolerance		
Nose bleeds			Cold intolerance		
Persistent Hoarseness_____			**Bone/joints**		
Cardiovascular			Painful joints		
Palpitations/irregular heartbeat			Swollen joints		
Chest pain			Muscle pain/tenderness		
Swollen ankles			**Neuromuscular**		
Respiratory			Dizzy, fainting spells		
Shortness of breath			**Psychological**		
Chest tightness			Increased stress		
Persistent cough			Depression		
Wheezing			Anxiety		
Rate your pain 0-10			Difficulty sleeping		