WELCOME TO AMITA ASTHMA & ALLERGY CENTER
303 E. ARMY TRAIL ROAD, SUITE 403
BLOOMINGDALE, IL 60108
Greg E. Sharon M.D. Noga Askenazi M.D.
Gurvinder (Gina) Herlihy PAC, Rebecca (Becky) Barager PAC
PHONE: 630-894-7083 FAX: 630-894-9472

PATIENT INFORMATION

Please complete the following form for each patient. The following information is necessary for ALL patients. If you need help with the form, the Receptionist will be happy to help you.

Please present your ***insurance card and a photo I.D.*** to the Receptionist with this completed form. Thank You!

LAST NAME: | FIRST NAME: | MID. INITIAL:

ADDRESS: | CITY: | STATE: | ZIP CODE:

HOME PHONE: _____
Preferred method of contact? ☐
Detailed voice message okay? ☐

CELL PHONE: _____
Preferred method of contact? ☐
Detailed voice message okay? ☐
Text message notifications okay? ☐

E-MAIL: _____
Preferred method of contact? ☐
Would you like a portal invitation? ☐

BIRTH DATE:

BIRTH SEX:
☐ MALE
☐ FEMALE

MARITAL STATUS:
☐SINGLE
☐MARRIED
☐DIVORCED
☐SEPARATED
☐WIDOWED

RACE:
☐American Indian/Alaska Native
☐Asian
☐Black or African-American
☐Native Hawaiian or Other Pacific Islander
☐White

SSN:

GENDER IDENTITY: _____

EMERGENCY CONTACT: _____
PHONE: _____ SECONDARY PHONE: _____
RELATIONSHIP: _____

ETHNICITY:
☐Hispanic or Latino
☐Not Hispanic or Latino

GUARANTOR/RESPONSIBLE PARTY: _____
DATE OF BIRTH: _____SSN: _____
ADDRESS (IF DIFFERENT): _____
PHONE: _____ RELATIONSHIP: _____
EMPLOYER: _____

PREFERRED LANGUAGE?
☐ English
☐ Spanish
☐ Other (please specify)
_____

PRIMARY CARD HOLDER ON INSURANCE:_____
(If different from patient and/or guarantor/responsible party)
RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____
ADDRESS: _____
EMPLOYER: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US?
☐ Referral from another patient (including family members)
☐ Referral from Immediate Care/ ER: _____
(Please specify facility & see box below)
☐ Referral from another Physician: _____
(Please specify physician & see box below)
☐ Other: _____

PRIMARY CARE PHYSICIAN/ PEDIATRICIAN:
NAME: _____
ADDRESS: _____
_____
PHONE NUMBER: _____
FAX NUMBER: _____

REFERRED PHYSICIAN/ FACILITY:
NAME: _____
SPECIALTY: _____
ADDRESS: _____
_____
PHONE NUMBER: _____
FAX NUMBER: _____
REFERRAL ORDER GIVEN? ☐ YES ☐ NO
*Please note that HMO insurance plans require written referral order to be seen by our physicians. It is the patient's responsibility to request and obtain written referral order from their primary physician's office. Referral must be presented at time of services or faxed prior to 630-894-9472.

PREFERRED PHARMACY: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____
CROSSROADS: _____

*Please note that medications prescribed by our providers are primarily sent directly via e-prescription to the pharmacy. If paper order preferred, please specify request to clinical staff. For mail order pharmacy prescriptions, a paper order will either be given or mailed to you to submit to your pharmacy (may be faxed by request, but fax number must be given.)

ASTHMA & ALLERGY CENTER
AMITA HEALTH

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Gurvinder Herlihy, PA • Rebecca Barager, PA

303 E. Army Trail Road Suite 403, Bloomingdale, IL 60108
(P) 630-894-7083 • (F) 630-894-9472

Patient Name: _____

Date: _____

IN THE <u>LAST 4 WEEKS</u> I HAVE HAD:

General: ☐Fever ☐Chills ☐Fatigue
☐Other_____

Ears, Nose, Throat: ☐Chronic Nasal Congestion ☐ Chronic Sinus Infection
☐Frequent Ear Infections
☐Ear Pressure
☐Other_____

Headaches: ☐Migraines ☐Tension ☐Sinus
☐Other
_____

Gastrointestinal: ☐Nausea
☐Vomiting ☐Diarrhea
☐Constipation
☐Heartburn ☐G.E.R.D.
☐Change in appetite
☐Other_____

Musculoskeletal: ☐Joint Pain ☐Joint Stiffness
☐Muscle Pain or Cramps
☐Other_____

Psychiatric: ☐Anxiety ☐A.D.D./A.D.H.D.
☐Depression ☐Memory loss ☐Panic disorder

Any additional item you would like addressed at today's visit?
_____
_____
_____

<u>Depression Screening</u>
☐***Refuse Screening***

Over the past two weeks, how often have you been bothered by feeling down or depressed?
☐Not at all ☐Several days
☐More than half the days ☐Nearly every day

Over the past two weeks, how often have you been bothered by little to no interest or pleasure in doing things?
☐not at all ☐several days
☐more than half the days ☐nearly every day

Eyes: ☐Itching ☐Redness ☐Watery Eyes
☐Other_____

Respiratory: ☐Chest Tightness
☐Shortness of breath (dyspnea)
☐Wheezing ☐ Cough
☐Other_____

Heart: ☐Chest pain or discomfort
☐High Blood Pressure
☐Heart Palpitations
☐Heart Murmur
☐Other_____

Skin: ☐Hives
☐Rashes
☐Eczema
☐Color changes
☐Hair and nail changes
☐Other_____

Endocrine: ☐Thyroid Disease ☐Diabetes
☐Frequent Thirst ☐Other_____

Surgeries or Hospitalizations (please list procedure with date):
_____

<u>Current Medications:</u>
Please list current medications (vitamins and supplements included).
_____
_____
_____
_____
_____
_____

<u>Failed Medications:</u>
Failed medications are medications that you have tried that do not alleviate your symptoms or that cause an adverse reaction. (Please include dates/duration of therapy)
_____
_____
_____
_____
_____

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

Please check off if you have a history of the following and explain when needed:

☐**Allergic rhinitis/ Hay fever** Affected areas: ☐eyes ☐nose	☐**Anxiety** Type: _____
☐**Arthritis** Type: _____	☐**Asthma** Treatment: _____
☐**Blackouts** When occurred: _____	☐ **Blood disorder** Type: _____
☐**Cancer** Type: _____ When: _____ Treatment: _____	☐**Cataracts** Surgery date: _____
☐**Chronic bronchitis** Date diagnosed: _____	☐**Celiac** Date diagnosed: _____
☐**Depression** Treatment: _____	☐**COPD** Date diagnosed: _____ Treatment: _____
☐**Drug allergy** When: _____ Type of reaction: _____	☐**Diabetes** Date diagnosed: _____ Treatment: _____
☐ **Eczema** Affected areas: _____	☐**Drug dependence** Type: _____
☐**Food Allergy** When: _____ Type of reaction: _____	☐ **Emphysema** ☐**GERD** Date diagnosed: _____ Treatment: _____
☐ **Glaucoma** Treatment: _____	☐**Gout** Treatment: _____

☐**Heart attack**

Date diagnosed: _____

Treatment: _____

☐ **Hypertension**

Date diagnosed: _____

Treatment: _____

☐ **Immune system disorder**

Type: _____

☐ **Kidney disease**

Date diagnosed: _____

Treatment: _____

☐ **Liver Disease**

Treatment: _____

☐ **Hepatitis**

Type: _____

☐ **Hyperlipidemia/ high cholesterol**

Treatment: _____

☐ **Insect allergy**

When: _____

Type of reaction: _____

☐ **IBS**

Date diagnosed: _____

Treatment: _____

☐ **Migraines**

How often: _____

Treatment: _____

☐ **Pneumonia**

Date diagnosed: _____

Treatment: _____

☐ **Seizures**

Type: _____

Treatment: _____

☐ **Thyroid disease**

Treatment: _____

☐**Past surgical history**

Date(s): _____

Type: _____

_____

_____

☐ **Sleep apnea**

Date diagnosed: _____

Treatment: _____

☐ **Stroke**

Date diagnosed: _____

Treatment: _____

☐ **Urticaria/hives**

How often: _____

Treatment: _____

☐ **Previous hospitalizations**

Date(s): _____

Type: _____

_____

☐ **Other medical history details (please detail in space below if not addressed in above boxes):**

_____

_____

_____

_____