

# ALLERGY HISTORY

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Number \_\_\_\_\_

Age \_\_\_\_\_

M/F

## Branson Allergy Symptom Evaluation™ (BASE)

### COMPLAINTS:

Please circle the appropriate number 0 to 3 according to severity:

**0 = absent** (no symptoms evident)

**2 = moderate** (tolerable)

**1 = mild** (symptoms present, but minimal awareness),

**3 = severe**

|                                 |         |                               |         |
|---------------------------------|---------|-------------------------------|---------|
| Nasal discharge (runny nose)    | 0 1 2 3 | Headache                      | 0 1 2 3 |
| Nasal obstruction (stuffy nose) | 0 1 2 3 | Hives                         | 0 1 2 3 |
| Nasal itching                   | 0 1 2 3 | Eczema                        | 0 1 2 3 |
| Sneezing                        | 0 1 2 3 | Itching ears                  | 0 1 2 3 |
| Watery eyes                     | 0 1 2 3 | Sinus or ear infections       | 0 1 2 3 |
| Itchy eyes                      | 0 1 2 3 | Frequent colds or sore throat | 0 1 2 3 |
| Gritty feeling (eyes)           | 0 1 2 3 | Sensitivity to pet hair       | 0 1 2 3 |
| Cough                           | 0 1 2 3 | Itchy throat                  | 0 1 2 3 |
| Wheezing                        | 0 1 2 3 | Sinus pressure                | 0 1 2 3 |
| Difficulty breathing            | 0 1 2 3 | Sinus pain                    | 0 1 2 3 |

Other symptoms causing you problems? \_\_\_\_\_

### MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never      1 = occasionally (several times a month or less)      2 = frequently (several times a week)

3 = daily

|                |         |  |         |
|----------------|---------|--|---------|
| Antihistamines | 0 1 2 3 | Nasal Steroids (Flonase, Nasacort)             | 0 1 2 3 |
| Oral Steroids  | 0 1 2 3 | Asthma medication (Inhaler, Singulair, Advair) | 0 1 2 3 |
| Eye drops      | 0 1 2 3 | Other allergy-related medications              | _____   |

Does any medication give you complete relief of symptoms? \_\_\_\_\_

### GENERAL ALLERGY HISTORY:

How many months of the year do you have allergies? \_\_\_\_\_ How many years? \_\_\_\_\_

In what season are they worse (check all that apply):  Spring       Summer       Fall       Winter

Have you been allergy tested before?  Yes  No

If yes, which type:  Skin prick/Puncture  Blood draw

Have you previously received allergy shots? \_\_\_\_\_ Allergy drops? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Do you smoke or use tobacco products? \_\_\_\_\_

List any animals you have in or around the home \_\_\_\_\_

Who else in your family has allergies? \_\_\_\_\_

### PROVIDER ONLY

RAW SCORE: \_\_\_\_\_

SCORE: \_\_\_\_\_ (Multiply raw score by 4)

0-25 = MILD 26-50=SIGNIFICANT

51-100 = SEVERE 100+= VERY SEVERE

# ALLERGY PROGRESS

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Number \_\_\_\_\_

Age \_\_\_\_\_

M/F

## COMPLAINTS:

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| Sneezing                        | 0 1 2 3 | Itching ears                  | 0 1 2 3 |
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| Cough                           | 0 1 2 3 | Itchy throat                  | 0 1 2 3 |
| Wheezing                        | 0 1 2 3 | Sinus pressure                | 0 1 2 3 |
| Difficulty breathing            | 0 1 2 3 | Sinus pain                    | 0 1 2 3 |

Other symptoms causing you problems?

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## MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never      1 = occasionally (several times a month or less)      2 = frequently (several times a week)

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Antihistamines 0 1 2 3      Nasal Steroids (Flonase, Nasacort) 0 1 2 3

Oral Steroids 0 1 2 3      Asthma medication (Inhaler, Singulair, Advair) 0 1 2 3

Eye drops 0 1 2 3      Other allergy-related medications \_\_\_\_\_

Does any medication give you complete relief of symptoms? \_\_\_\_\_

## ALLERGY TREATMENTS (Immunotherapy):

In period of time since your last visit, how consistent have you been with taking the allergy treatment as prescribed?

0 = never      1 = occasionally (several times a month or less)      2 = frequently      3 = very

Comments or concerns about your progress:

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# ALLERGY TEST RESULTS

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Number \_\_\_\_\_

Age \_\_\_\_\_

M/F

PATIENT HAS TAKEN ORAL ANTI-HISTAMINES IN LAST 24 HOURS?

Yes

No

MARK ALL RESULTS OF SKIN TEST IN MM:

**GROUP A1 -----GROUP A2**

\_\_\_\_\_ NEG CONTROL  
\_\_\_\_\_ DOG EPITHELIA  
\_\_\_\_\_ CAT HAIR  
\_\_\_\_\_ ALT. ALTERNATA  
\_\_\_\_\_ CLADO. HERB.

\_\_\_\_\_ POS CONTROL  
\_\_\_\_\_ CLADOSPORIUM SPHAERO  
\_\_\_\_\_ RUSSIAN THISTLE  
\_\_\_\_\_ GRASS MIX  
\_\_\_\_\_ JOHNSON GRASS

**GROUP B1 -----GROUP B2**

\_\_\_\_\_ BERMUDA  
\_\_\_\_\_ COCKROACH MIX  
\_\_\_\_\_ MITE MIX  
\_\_\_\_\_ SAGEBRUSH, COMMON  
\_\_\_\_\_ MAPLE-BOX ELDER MIX

\_\_\_\_\_ ALDER, WHITE  
\_\_\_\_\_ WINGSCALE  
\_\_\_\_\_ COTTONWOOD, FREMONT  
\_\_\_\_\_ ELM, SIBERIAN  
\_\_\_\_\_ CALIFORNIA SYCAMORE POLLEN

**GROUP C1 -----GROUP C2**

\_\_\_\_\_ MULBERRY, WHITE  
\_\_\_\_\_ OAK, GAMBEL  
\_\_\_\_\_ PECAN  
\_\_\_\_\_ ACACIA  
\_\_\_\_\_ WALNUT, CA. BLACK

\_\_\_\_\_ WILLOW, ARROYO  
\_\_\_\_\_ PALM, QUEEN  
\_\_\_\_\_ PINE, PONDEROSA  
\_\_\_\_\_ BIRCH, RIVER  
\_\_\_\_\_ MESQUITE

**GROUP D1 -----GROUP D2**

\_\_\_\_\_ DOCK-SORREL MIX  
\_\_\_\_\_ WESTERN RAGWEED MIX  
\_\_\_\_\_ BACCHARIS  
\_\_\_\_\_ FIREBUSH/KOCHIA  
\_\_\_\_\_ LAMB'S QUARTER

\_\_\_\_\_ MARSH ELDER, BURWEED  
\_\_\_\_\_ NETTLE  
\_\_\_\_\_ PIGWEED, ROUGH/REDROOT  
\_\_\_\_\_ PLANTAIN, ENGLISH  
\_\_\_\_\_ HACKBERRY

OFFICE USE ONLY - ROS

|   |  |  |   |
|---|--|--|---|
| H10.45 Other chronic allergic conjunctivitis                | H65.01 Acute serous otitis media, right ear                        | H65.02 Acute serous otitis media, left ear                   | H65.03 Acute serous otitis media, bilateral                   |
| H65.04 Acute serous otitis media, recurrent, right ear      | H65.05 Acute serous otitis media, recurrent, left ear              | H65.06 Acute serous otitis media, recurrent, bilateral       | H65.21 Chronic serous otitis media, right ear                 |
| H65.22 Chronic serous otitis media, left ear                | H65.23 Chronic serous otitis media, bilateral                      | H65.411 Chronic allergic otitis media, right ear             | H65.412 Chronic allergic otitis media, left ear               |
| H65.413 Chronic allergic otitis media, bilateral            | H65.491 Other chronic non-suppurative otitis media, right ear      | H65.492 Other chronic non-suppurative otitis media, left ear | H65.493 Other chronic non-suppurative otitis media, bilateral |
| H66.91 Otitis media, unspecified, right ear                 | H66.92 Otitis media, unspecified, left ear                         | H66.93 Otitis media, unspecified, bilateral                  | J01.00 Acute maxillary sinusitis, unspecified                 |
| J01.01 Acute recurrent maxillary sinusitis                  | J01.10 Acute frontal sinusitis, unspecified                        | J01.11 Acute recurrent frontal sinusitis                     | J01.20 Acute ethmoidal sinusitis, unspecified                 |
| J01.21 Acute recurrent ethmoidal sinusitis                  | J01.30 Acute sphenoidal sinusitis, unspecified                     | J01.31 Acute recurrent sphenoidal sinusitis                  | J01.40 Acute pansinusitis, unspecified                        |
| J01.41 Acute recurrent pansinusitis                         | J01.80 Other acute sinusitis                                       | J01.81 Other acute recurrent sinusitis                       | J01.90 Acute sinusitis, unspecified                           |
| J01.91 Acute recurrent sinusitis, unspecified               | J04.0 Acute laryngitis   | J04.30 Supraglottitis, unspecified, without obstruction      | J04.31 Supraglottitis, unspecified, with obstruction          |
| J05.0 Acute obstructive laryngitis [croup]                  | J30.0 Vasomotor rhinitis   | J30.1 Allergic rhinitis due to pollen                        | J30.2 Other seasonal allergic rhinitis                        |
| J30.5 Allergic rhinitis due to food                         | J30.81 Allergic rhinitis due to animal (cat) (dog) hair and dander | J30.89 Other allergic rhinitis                               | J31.0 Chronic rhinitis  |
| J31.1 Chronic nasopharyngitis                               | J31.2 Chronic pharyngitis  | J32.0 Chronic maxillary sinusitis                            | J32.1 Chronic frontal sinusitis                               |
| J32.2 Chronic ethmoidal sinusitis                           | J32.3 Chronic sphenoidal sinusitis                                 | J33.0 Polyp of nasal cavity                                  | J33.8 Other polyp of sinus                                    |
| J34.3 Hypertrophy of nasal turbinates                       | J34.81 Nasal mucositis (ulcerative)                                | J34.89 Other specified disorders of nose and nasal sinuses   | J35.01 Chronic tonsillitis                                    |
| J35.02 Chronic adenoiditis                                  | J35.03 Chronic tonsillitis and adenoiditis                         | J35.1 Hypertrophy of tonsils                                 | J35.2 Hypertrophy of adenoids                                 |
| J35.3 Hypertrophy of tonsils with hypertrophy of adenoids   | J45.20 Mild intermittent asthma, uncomplicated                     | J45.21 Mild intermittent asthma with (acute) exacerbation    | J45.22 Mild intermittent asthma with status asthmaticus       |
| J45.30 Mild persistent asthma, uncomplicated                | J45.31 Mild persistent asthma with (acute) exacerbation            | J45.32 Mild persistent asthma with status asthmaticus        | J45.40 Moderate persistent asthma, uncomplicated              |
| J45.41 Moderate persistent asthma with (acute) exacerbation | J45.42 Moderate persistent asthma with status asthmaticus          | J45.50 Severe persistent asthma, uncomplicated               | J45.51 Severe persistent asthma with (acute) exacerbation     |
| J45.52 Severe persistent asthma with status asthmaticus     | J45.901 Unspecified asthma with (acute) exacerbation               | J45.902 Unspecified asthma with status asthmaticus           | J45.909 Unspecified asthma, uncomplicated                     |
| J45.991 Cough variant asthma                                | J45.998 Other asthma   | R05 Cough  | R06.02 Shortness of breath                                    |
| R06.09 Other forms of dyspnea                               | R06.2 Wheezing   |  |   |

STATEMENT OF MEDICAL NECESSITY:

Previously tried Treatments/Medications: \_\_\_\_\_

Check all that apply:

- 95004 (38 Units) Allergy Skin Test (Environmental) Other units \_\_\_\_\_
- 95165 (180 Units) Allergy Immunotherapy for pos. result Other units \_\_\_\_\_
- Date of Service to Begin Treatment (72 hours from today's date) \_\_\_\_\_
- 90471 Allergy Vaccine Administration Other \_\_\_\_\_

The patient was tested for allergies to assist in symptomatic relief, and improve health and wellness. Prior to the test the patient was informed of possible risks and benefits of the allergy test and associated treatment. Refer to the patient file for a more complete allergy history, performed test forms, and test results.

Provider \_\_\_\_\_ SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

Provider \_\_\_\_\_ SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

## Allergen Immunotherapy Patient Informed Consent

Patient Name \_\_\_\_\_

Date. \_\_\_\_\_

Patient Number \_\_\_\_\_

Age \_\_\_\_\_

M/F

Initial immunotherapy, hyposensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal. You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician (see information sheet). I have read (if new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction. I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared up to 1½ weeks prior to my appointment. I agree to obtain prior authorization, if needed, from my insurance plan.

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

### FOR MINORS ONLY:

PARENT or LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait.

Office Staff \_\_\_\_\_ DATE \_\_\_\_\_