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)
1 = mild (symptoms present, but minimal awareness),
2 = moderate (tolerable)
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): O Spring O Summer O Fall O Winter
Have you been allergy tested before? O Yes O No
If yes, which type: O Skin prick/Puncture O 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:

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? _____

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:

_____

_____

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 (MOLD)
_____CLADO. HERB. (MOLD)

_____POS CONTROL
_____CLADOSPORIUM SPHAERO (MOLD)
_____RUSSIAN THISTLE (WEED)
_____GRASS MIX (GRASS & GRASS POLLEN)
_____JOHNSON GRASS (GRASS/WEED)

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

_____BERMUDA (GRASS)
_____COCKROACH MIX (INSECT)
_____MITE MIX (INSECT)
_____SAGEBRUSH, COMMON (SHRUB)
_____MAPLE-BOX ELDER MIX (TREE)

_____ALDER, WHITE (TREE)
_____WINGSCALE (SHRUB)
_____COTTONWOOD, FREMONT (TREE)
_____ELM, SIBERIAN (TREE)
_____CALIFORNIA SYCAMORE (TREE)

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

_____MULBERRY, WHITE (TREE)
_____OAK, GAMBEL (TREE)
_____PECAN (TREE)
_____ACACIA (TREE)
_____WALNUT, CA. BLACK (TREE)

_____WILLOW, ARROYO (TREE)
_____PALM, QUEEN (TREE)
_____PINE, PONDEROSA (TREE)
_____BIRCH, RIVER (TREE)
_____MESQUITE (TREE)

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

_____DOCK-SORREL MIX (HERB)
_____WESTERN RAGWEED MIX (WEED)
_____BACCHARIS (SHRUB)
_____FIREBUSH/KOCHIA (WEED)
_____LAMB'S QUARTER (WEED)

_____MARSH ELDER, BURWEED (WEED)
_____NETTLE (WEED)
_____PIGWEED, ROUGH/REDROOT (WEED)
_____PLANTAIN, ENGLISH (WEED)
_____HACKBERRY (TREE)

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 nonsuppurative 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:

- p 95004 (38 Units) Allergy Skin Test (Environmental) Other units_____
- p 95165 (180 Units) Allergy Immunotherapy for pos. result Other units_____
  Date of Service to Begin Treatment (72 hours from today's date) _____
- p 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_____