CATHERINE G. FULLER, M.D.

Board Certified Asthma and Allergy

Patient Information Marital Status: □ Single □ Married □ Divorced □ Widowed Sex: □ Male □Female **Today's Date**_____

Name: _____ Age:_____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Responsible Party SS#_____ Email: _____

Responsible Party Information (If different from above) Pharmacy #_____

Spouse/Father's Name:_____ Mother's Name: _____

Age:_____ Date of Birth:_____ Age: _____ Date of Birth: _____

Street Address:_____ Street Address: _____

City:_____ State: _____ Zip:_____ City:_____ State: _____ Zip:_____

Home Phone: (___)_____ Home Phone: (___)_____

Cell Phone: (___)_____ Cell Phone: (___)_____

Work Phone: (___)_____ Work Phone: (___)_____

Employer:_____ Employer:_____

Address:_____ Address:_____

Emergency Contact

Name:_____ Phone: (___)_____ Relationship to Patient:_____

Patient Referral Information

Referred by:_____ If referred by friend, may we thank her or him? □Yes □No

Name(s) of other physician(s) who care for you:_____

Acknowledgement of Receipt
I hereby acknowledge I have received a copy of Comprehensive Allergy & Asthma Associates's Notice of Privacy Practices.
Patient/Representative's Name:_____ Signature:_____Date:_____

I am aware Dr. Catherine G. Fuller is a non-contracted/out of network provider. This means fees will be collected at the time of your visit and claim forms must then be submitted to your insurance for reimbursement. Also, I understand I am financially responsible for all charges incurred during the visit with Dr. Catherine G. Fuller.

Signature:_____ Date:_____

I agree to the service stated above and authorize the release of any medical information to process the claim.

COMPREHENSIVE ALLERGY AND ASTHMA ASSOCIATES
11645 WILSHIRE BLVD. SUITE 1150
LOS ANGELES, CALIFORNIA 90025
PHONE: (310) 909-1910 FAX: (310) 909-1911

DR. CATHERINE FULLER

Patient Name: **DOB:** **Today's Date:**

Allergy Questionare

How were you reffered?

Physician(name): **Self Referral:** **Other:**

What problems brings you or your child to this appointment?:

When did symptoms begin?:

Are your symptoms getting worse?: ☐YES ☐NO

Do you have any of these symptoms?(Please check all that apply)

☐Cough	☐Runny Nose	☐Nasal Polyps	☐Eczema
☐Wheezing	☐Nasal Congestion	☐Poor sense of smell	☐Hives/Swelling
☐Shortness of Breath	☐Itchy Nose	☐Sinus Infections	☐Headaches
☐Chest Tightness	☐Itchy/Watery Eyes	☐Post Nasal Drip	☐Snoring
☐Sneezing	☐Mouth Breathing	☐Phlegm/Sputum(Color)_____	☐Fatigue
		☐Blocked Ears	☐Other

Check any of the following which seem to trigger(or cause) symptoms that bother you:

☐Santa Ana Winds	☐Cats	☐Cosmetics	☐House Dust	☐Cold Air
☐Grass	☐Dogs	☐Aerosol Sprays	☐Smoke	☐Humidity
☐Hay	☐Horses	☐Perfumes	☐Pollution	☐Weather Changes
☐Mold and Mildew	☐Other animals	☐Odors	☐Exercise	☐Latex(rubber)
☐Leaves	☐Alcoholic Beverages	☐Drafts	☐Anxiety	☐Other

When are your symptoms worse?:

☐January	☐May	☐September	☐Year Round
☐February	☐June	☐October	
☐March	☐July	☐November	
☐April	☐August	☐December	

Are symptoms better away from home: ☐YES ☐NO **If yes, Where?:**

Have you been skin tested?: ☐YES ☐NO

Skin test results:

Have you had allergy injections: ☐YES ☐NO **If yes, when?:**

Have you received cortisone (Prednisone,Medrol,Prelone,Orapred) drugs? ☐YES ☐NO

When: **How Much:**

Occupation(current or former)?:

Any harmful exposure at work or school?:

ENVIRONMENTAL SURVEY

How long have you lived in your house/apartment?: _____

Do you live in a: ☐House ☐Apartment/Duplex ☐ Condominium/Townhouse

Approximately how old is your house/apartment/condo?: _____

Do you live in: ☐In the city ☐In the suburbs ☐Rural Areas

Do you have a basement/crawlspace?: ☐YES ☐NO

Is your house built on a slab?: ☐YES ☐NO

Type of heating system?: ☐Hot Air ☐Steam(radiator) ☐Electric ☐Hotwater(baseboard)

Do you have: ☐Wood ☐Humidifiers ☐Dehumidifier ☐Air Cleaner

Pets(Please indicate how many): ☐INDOOR ☐OUTDOOR ☐CATS____ ☐DOGS____ ☐BIRDS____ ☐OTHER_____

Are there any tabacco smokers in your home? ☐YES ☐NO

Is your bedroom in the basement? ☐YES ☐NO

Do you have allergy proof encasing for pillow or mattress? ☐YES ☐NO

What type of pillows do you have?: _____

What type of comforter do you have?: _____

How old is your mattress?: _____

What type of floor coverings do you have in your bedroom? ☐Wall to Wall ☐Area Rug ☐Hardwood or Tile

Do you have air conditioning? ☐YES ☐NO

Do you have water leaks or damage, mold?: ☐YES ☐NO

Is your home/apartment excessively humid?: ☐YES ☐NO

YOUR PAST MEDICAL HISTORY

(Check all that apply)

☐Diabetes	☐Heart Problems(Murmu	☐Peptic Ulcer	☐Heartburn/reflux
☐Cancer	☐Osteoporosis	☐Thyroid Disease	☐Seizures
☐High Blood Pressure	☐Asthma	☐Arthritis	☐Migraines
☐Anemia/Blood Disorder	☐Glaucoma	☐Hay Fever	☐Depression
☐Kidney/Bladder Disease	☐Autoimmune Disease	☐Diarrhea	☐Anxiety
☐Liver Disease(Hepatitis)	☐Loss of sense of taste	☐Cataracts	☐Tension Headaches
		☐Emphysema	☐Sinus Headaches

If yes to any of the above, please explain: _____

Have you had your tonsils or adenoids removed?: ☐YES ☐NO

Have you or your child had ear tubes?: ☐YES ☐NO

Have you had ear, nose or sinus surgery?: ☐YES ☐NO

If yes, please explain: _____

FAMILY HISTORY

Who in your family has had: (Not including yourself)

☐Asthma

☐Eczema

☐Seasonal/Year Round Allergies

☐Other allergies (drugs/bee sting/food/etc)

☐Sinus Problems

Please list any hospitalizations regardless of cause:

List any food allergies and reactions experienced:

List any drug or latex allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, etc.)

Describe any reaction to insect stings:

List all medications and dosages (including nasal sprays, non-allergy medications and alternative/herbal products)

Do you smoke?: ☐YES ☐NO **How Much?:**

Have you smoked in the past?: ☐YES ☐NO **When stoppped?:**

If yes, how many years have you smoked?:

Are there smokers in the house?: ☐YES ☐NO

DO NOT WRITE IN THIS SECTION: B/W: P/L/D: BF: