

## New Patient Packet

Please print and complete the enclosed medical forms and bring them with you to your first appointment.

Please use Black ink only

[Do not mail or email back to us.](#)

Before your appointment, please obtain your last two clinic notes from your PCP/specialist, any pertinent lab test results and any scans/x-rays related to your condition. Please bring this data with you to your first clinic visit.

**Vanderbilt Asthma Sinus and Allergy Program**  
p. 615.936.2727 f. 615.936.5767 toll free 1.866.390.0379  
www.vanderbiltallergy.com

Welcome to the Vanderbilt Asthma, Sinus and Allergy Program. The following information will assist you with your visit. Please read and complete all enclosed medical forms.

**We ask that you arrive 15 minutes before your scheduled appointment time.**

**Appointment day:** \_\_\_\_\_

**Appointment time:** \_\_\_\_\_

**Arrival time:** \_\_\_\_\_

**You are scheduled at the following ASAP site: (circle one below)**

**2611 West End Ave   Brentwood   Franklin   Lebanon   Gallatin**

**To insure best directions from your starting location; please use GPS or Mapquest.**

**VASAP @ 2611 West End Ave.** between the Holiday Inn and J. Alexanders Redlands Grill restaurant, across the street from Centennial Park. **Parking:** Park at the rear of our building in the lot that we share with the Holiday Inn. Enter the second floor of the building by crossing the covered walkway.

**VASAP @ The Shoppes at Brentwood** - 782 Old Hickory Blvd., Ste 203 Brentwood, TN 37027 **Parking:** The Shoppes at Brentwood parking lot.

**VASAP @ Franklin** – 919 Murfreesboro Rd, Franklin, TN 37064

**VASAP @ Lebanon** – 1409 W Baddour Pkwy, Suite E, Lebanon, TN 37087

**VASAP @ Gallatin** – 300 Steam Plant Rd, Suite 460, Gallatin, TN 37066

• **What to expect:** Our team of healthcare providers will provide you with a thorough evaluation and will design an individualized education and treatment plan based on your evaluation findings. Tests that may be ordered may include allergy testing, sinus CT scans, pulmonary function tests, and/or chest x-rays. All proposed testing will be thoroughly explained and discussed with you. Should you have any questions or specific needs regarding your visit, please contact us.

• **Preparation:** To enable us to provide you with a thorough evaluation, **please allow 4 hours for your** initial visit. Due to the extensiveness of this evaluation, we ask that young children do not accompany you. Read all enclosed materials – especially note which medications need to be withheld in order to complete testing. Complete all enclosed medical forms ahead of time and bring these with you. **Please do not wear (or anyone with you) any kind of perfume, after shave or fragranced lotions.**

• **Cancellations:** While it is understood that patients' schedules can change, we do require a minimum of 24 hour notice if you cannot keep your appointment. Please call us immediately at 615-936-2727 if you need to reschedule.

Insurance/Referral/ Payment for Services

• **Insurance/Referrals:** If your insurance requires a referral from your primary care provider for your visit with us, **YOU** must obtain this before your visit. If you do not have your referral form, you will be given the option to reschedule your visit or pay for the visit at the time the service is rendered and file with your insurance company yourself. Your PCP or referring physician may fax these forms to us at 615-936-5767 prior to your visit. If you have questions, please call us at 615-936-2727. **Please bring your insurance card with you.**

**IT IS YOUR RESPONSIBILITY TO CHECK YOUR INSURANCE FOR BENEFIT AND COVERAGE INFORMATION PRIOR TO YOUR APPOINTMENT INCLUDING CO-INSURANCE, CO-PAYMENT AND DEDUCTIBLE AMOUNTS THAT MAY BE DUE BY THE PATIENT.**

**You will be expected to pay for your co-pay and/or any out of pocket expense at time of service.**

**\* To determine what your insurance provider will cover, you may use this tool to verify benefits and coverage prior to your appointment by calling your insurance provider and providing these codes.**

TEST	INSURANCE CODE BILLED
<b>CT scan of the Maxillofacial Sinus</b> (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the imaging service)	<b>70486</b>
Deductible: Y/N _____	Amount \$: _____
Coinsurance: Y/N _____	Amount %: _____
Co-Pay: Y/N _____	Amount \$: _____
<b>Allergy Skin Testing</b>	
<b>Allergy Skin Testing</b> (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the allergy skin testing)	<b>95004 and /or 95024</b>
Deductible: Y/N _____	Amount \$: _____
Coinsurance: Y/N _____	Amount %: _____
Co-Pay: Y/N _____	Amount \$: _____
<b>Spirometry (breathing treatment for your lungs)</b>	
<b>Spirometry (breathing treatment for your lungs)</b> (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the breathing treatments)	<b>94010 and /or 94060</b>
Deductible: Y/N _____	Amount \$: _____
Coinsurance: Y/N _____	Amount %: _____
Co-Pay: Y/N _____	Amount \$: _____

Does my insurance require a referral to a specialist? Y/N \_\_\_\_\_

Does my insurance require me to use a specific laboratory when blood test or other specimen collection for treatment is performed? Y/N \_\_\_\_\_

If yes, name of laboratory: \_\_\_\_\_

New Patient Checklist for Initial Clinical Visit

- Eat breakfast
- Wear comfortable clothes and shoes
- If this is your first visit, please plan on being at the ASAP Clinic for a **minimum of 4 hours**
- Please call **Central Registration (888-567-5255 or 615-322-2971)**, if you have not done so already to complete registration and verification of insurance or payment arrangement.
- Completed Patient Information form
- Completed Medication form
- Completed ASAP Patient Questionnaire form
- Bring your insurance card / information to your first appointment
- Provide us with your pharmacy name, address, phone and FAX numbers
- Referral (if required)**
- Arrive 15 minutes prior to your appointment – we do our best to see patients timely, however, unforeseen events may cause delays. We do try our best to keep on schedule as much as possible
- Prior to visiting us on your first visit to Vanderbilt ASAP – register for *MyHealthatVanderbilt.com*. This website allows you to send emails to us regarding appointments and prescription refills. Once you have registered and visited us in the office we can update your status so you can review your lab results.
- Reading material or personal entertainment (iPods w/headphones, etc) to help pass the time between testing and clinic consultation with your provider

Any questions, please do not hesitate to contact us AT 615-936-2727.

Sincerely,

VANDERBILT ASTHMA SINUS ALLERGY PROGRAM (ASAP)

## PATIENT MEDICATION INSTRUCTIONS

- 1) Please discontinue use of antihistamines at least 5 days before appointment, unless you need them for hives, asthma, swelling or severe allergic reactions.

### **ANTI-HISTAMINES:**

Accuhist	Deconamine
Actifed	Dimetapp
Advil Allergy Sinus	Doxepin Naldecon (cyproheptadine)
Alavert (Loratadine)	Nyquil
Allegra / Allegra D (Fexofenadine)	Periactin
Antivert (Meclizine)	Phenergan (Promethazine)
Atarax (Hydroxyzine)	Rescon
Benadryl (diphenhydramine)	Rynatan (azatadine)
Brompheniramine	Triaminic
Chlorpheniramine	Tylenol Allergy Sinus
Claritin / Claritin D (Loratadine)	Tylenol PM
Clarinex	Tussi-12
Compazine	Xyzal (levocetirizine)
	Zyrtec / Zyrtec D (cetirizine)

### **NASAL SPRAY ANTI-HISTAMINE**

Astelin  
Astepro  
Patanase

**MEDICATIONS**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

YOUR PHARMACY: \_\_\_\_\_ PHARMACY PHONE # \_\_\_\_\_

PLEASE LIST BELOW **ALL** MEDICATIONS THAT YOU **CURRENTLY** TAKING.

(PLEASE INCLUDE ALL PRESCRIPTION, OVER THE COUNTER AND NON-PRESCRIPTION DRUGS, INCLUDING BIRTH CONTROL PILLS, INSULIN, ASPIRIN, SINUS MEDICATIONS, HORMONES, PATCHES, OINTMENTS, INJECTIONS, NASAL SPRAYS, ETC.)

NAME OF MEDICATION	STRENGTH OR DOSE	HOW MANY PER DAY/TIMES?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ADDITIONALLY, LIST ANY MEDICATIONS THAT YOU HAVE TAKEN IN THE LAST **MONTH** FOR ANY CONDITION.

NAME OF MEDICATION	STRENGTH OR DOSE	HOW MANY PER DAY/TIMES?
1.		
2.		
3.		
4.		

**MEDICATION/DRUG ALLERGIES:**

Please list below any medication/drug which you cannot take due to an allergy or a side effect from taking the drug and the reaction which occurs.

Name of Medication/Drug	Type of Reaction
1.	
2.	
3.	
4.	

**ASAP QUESTIONNAIRE**

PLEASE COMPLETE IN BLACK INK

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Do you have any problems with any of the following?

	Yes	No		Yes	No
Nasal congestion	_____	_____	Throat clearing	_____	_____
Runny nose	_____	_____	Hoarseness	_____	_____
Itchy /watery eyes	_____	_____	Loss of sense of smell	_____	_____
Facial pressure/pain	_____	_____	Itching (skin)	_____	_____
Headaches	_____	_____	Swelling (skin)	_____	_____
Sinus infections	_____	_____	Eczema	_____	_____
Sneezing	_____	_____	Coughing	_____	_____
Post-nasal drainage	_____	_____	Shortness of breath	_____	_____
			Wheezing	_____	_____

**Allergy:** Please circle answers: Do you have allergies or hay fever? Yes No Don't know  
 Have you ever been tested for allergies? Yes No What type of testing? Skin Blood (RAST)  
 Did you get allergy shots? Yes No For how long? \_\_\_\_\_ Were they helpful? Yes No  
 Do you have any history of allergies to the following? Circle: Foods Latex Insect stings

**Sinus:** Do you have a history of sinus problems? Yes No Color of drainage today? \_\_\_\_\_  
 How many times have you been treated for a sinus infection with antibiotics in the last year? \_\_\_\_\_  
 Have you ever had an x-ray or CT scan if your sinuses? Yes No If yes, when and where? \_\_\_\_\_  
 Have you ever had sinus surgery? Yes No If yes, when and where? \_\_\_\_\_ Did surgery help? Yes No

**Asthma:** Have you ever been diagnosed with asthma? Yes No  
 Have you ever been to the emergency room because of you asthma? Yes No How often? \_\_\_\_\_  
 Have you ever had to stay overnight in the hospital for your asthma? Yes No How often? \_\_\_\_\_

**REVIEW OF SYMPTOMS:** Please indicate if you have had any of the following **IN THE LAST 30 DAYS:**

	Yes	No		Yes	No
Fever	_____	_____	Indigestion/Heartburn	_____	_____
Weight change	_____	_____	Constipation	_____	_____
Fatigue	_____	_____	Diarrhea	_____	_____
Sleep problems/snoring	_____	_____	Trouble swallowing	_____	_____
Skin rashes/hives	_____	_____	Urinary abnormalities	_____	_____
Unusual bruising/bleeding	_____	_____	Muscle pain, aches or cramps	_____	_____
Heart pounding/palpitations	_____	_____	Joint pain	_____	_____
Chest pain	_____	_____	Depression – feeling blue	_____	_____
Swollen ankles	_____	_____	Anxiety – feeling nervous	_____	_____
Dizziness	_____	_____	Problems with hearing	_____	_____
Nausea/vomiting	_____	_____	Problems with vision	_____	_____

**General:** Have you had a chest x-ray or chest CT in the last year? Yes No Results: \_\_\_\_\_  
 Have you had pneumonia vaccine shot (Pneumovax )? Yes No  
 Do you normally get a flu shot every year? Yes No  
 How many times in the last year have you had to take oral or injected steroids, such as prednisone or a Medrol dose pack? \_\_\_\_\_  
 Are there any family disputes/situations that make your or your child's care more difficult? \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Past Medical History:** Do you have or have ever had any of the following conditions?

	Yes	No		Yes	No
Hives	_____	_____	Bowel/Intestinal disorder	_____	_____
Thyroid disease	_____	_____	Liver condition	_____	_____
Diabetes/blood sugar problems	_____	_____	Stomach ulcer	_____	_____
Pneumonia	_____	_____	Acid reflux	_____	_____
Tuberculosis	_____	_____	Anemia/low blood	_____	_____
Positive TB skin test	_____	_____	Stroke/"mini strokes"	_____	_____
Frequent bronchitis	_____	_____	Bleeding disorder	_____	_____
COPD/emphysema	_____	_____	Cancer	_____	_____
Other lung condition	_____	_____	Neurological condition	_____	_____
Frequent strep throat	_____	_____	Seizures/epilepsy	_____	_____
Sleep apnea	_____	_____	Migraine headaches	_____	_____
CPAP machine	_____	_____	Cataracts	_____	_____
Heart arrhythmia/palpitations	_____	_____	Glaucoma	_____	_____
Heart problems	_____	_____	Arthritis	_____	_____
High blood pressure	_____	_____	Back/spine problems	_____	_____
High cholesterol	_____	_____	Osteoporosis	_____	_____
Hepatitis	_____	_____	Depression/sadness	_____	_____
HIV/AIDS	_____	_____	Panic attacks/anxiety	_____	_____
Kidney disease/decreased function	_____	_____	Other psychiatric conditions	_____	_____
Gynecology/female problems	_____	_____	Alcoholism/drug dependency	_____	_____
Male genital/prostate problems	_____	_____			

**Family History:**

	Parent		Sibling		Child		Grandparent	
	Mother/Father		Male/Female		Male/Female		Maternal/Paternal	
Asthma	_____	_____	_____	_____	_____	_____	_____	_____
Sinus disease	_____	_____	_____	_____	_____	_____	_____	_____
Hay fever/allergies	_____	_____	_____	_____	_____	_____	_____	_____
Cystic fibrosis	_____	_____	_____	_____	_____	_____	_____	_____
Emphysema	_____	_____	_____	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____

**Surgeries/Hospitalizations:** Please list all hospitalizations and surgeries and the years these occurred:


**Social History:**

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Do you use/have you used tobacco products? Yes No Past Circle: Cigarettes cigars pipe snuff chew dip

How many per day? \_\_\_\_\_ How many years? \_\_\_\_\_ If you've stopped, when did you stop? \_\_\_\_\_

Have you been exposed to second hand cigarette smoke? \_\_\_\_\_ Where? \_\_\_\_\_

Do you use alcohol? Yes No Drinks per week? \_\_\_\_\_ Other drug use? Yes No

Do you have any HIV risk factors? Yes No

**Environmental History:**

Do you have any pets in the home? Yes No Cats Dogs Other Inside Outside Both

Do pets sleep in your bedroom? Yes No

Has there been any water leakage or water damage in your home? Yes No If yes, has this been repaired? Yes No

What type of flooring? Carpet Hardwood Tile Vinyl Other

**FOR OFFICE USE: REVIEWED AND CONFIRMED WITH PATIENT BY:** \_\_\_\_\_ **VISIT DATE?** \_\_\_\_\_