BEACHWOOD
24400 Highpoint #1
Beachwood, OH 44122
216-831-4930

WESTLAKE
805 Columbia Rd #101
Westlake, OH 44145
440-777-9969

STRONGSVILLE
16000 Pearl Rd #219
Strongsville, OH 44149
440-238-1304

MENTOR
7200 Mentor Ave #101
Mentor, OH 44060
440-953-8008

PARMA
6681 Ridge Rd #404
Parma, OH 44129
440-843-8008

FAIRLAWN
3094 W. Market St #14
Fairlawn, OH 44333
330-836-9232

ALLERGY DIAGNOSTIC SYSTEMS, INC.

Barry A. Lampl, D.O.
FAOCAI

Please fill out the attached paperwork in full.

Your appointment is scheduled for _____@_____.
WE REQUIRE 24 hr ADVANCE NOTICE OF CANCELLATIONS

REMINDERS:

1. **DO NOT take anything that may contain an antihistamine after:**

_____

(i.e. Claritin, Zyrtec, Benadryl, Allegra
reflux medications:Zantac and Pepcid
and certain sleep aids, cold pills, cough syrups, and nasal sprays)

2. **Wear a short-sleeved shirt.**
3. **You will be with us for approximately 1 1/2 hours.**
4. **Please bring your insurance card(s) in with you.**
5. **Please bring the names of all medications currently being taken.**

If you have any questions, please phone our office @ 216-831-4930

We have contacted your insurance company. Below is the coverage information provided to us by a representative.

****DEDUCTIBLE_____**

** **OFFICE CO-PAY _____**
(PLEASE PAY AT THE TIME OF YOUR OF VISIT)

** **ALLERGY TESTING, SHOTS, AND RESPIRATORY TESTING COVERED AT _____**

** **PRE-EXISTING CLAUSES _____**

ALLERGY DIAGNOSTIC **DATE_____** **PATIENT INFORMATION**

Last Name	First Name	Middle Name	Suffix

Social Sec #	Date of Birth	Gender	Marital Status
		Male / Female	Divorced / Married / Single / Widowed

Street Address	Home Phone	

Line 2	Work Phone	

City	State	Zip	Country	Cell Phone	

Emergency Contact	Emergency Contact Phone	Best Contact for Appointment Reminder?
		Home_____ Work_____ Cell Call_____ Cell Text_____

Guarantor Name	Relationship	Guarantor Address, City Zip	Guarantor Contact Number

Primary Insurance Name	Policy Number	Group Number	Subscriber's Name/Relationship to Patient/DOB	Copay Amt

Secondary Insurance Name	Policy Number	Group Number	Subscriber's Name/Relationship to Patient/DOB	Copay Amt

Primary Care Doctor / Phone	Referred by?

How did you hear about our practice?

Doctor Internet Newspaper Pharmacy Bag Telephone Friend/Relative:_____

Local Pharmacy	Phone Number	Location of Pharmacy	Patient Email

AUTHORIZATION

Patient or Authorized Person's Signature Required:

I hereby authorize Dr. Barry Lampl and his staff to submit my claims to my insurance carrier for all services and I understand that I am financially responsible for balances not covered. I authorize the release of any medical or other information necessary to process these claims. I authorize payment of medical benefits to the above physicians for services provided.

_____ **Date:**_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

Allergy Diagnostics

Patient Name _____ Date _____

Chronic Urticaria
Quality of Life Questionnaire (CU-Q2 oL)

Complete this questionnaire. Your responses will help you doctor assess how you chronic idiopathic urticaria (CIU) is impacting you quality of life. Please circle the score that best describes the importance of each of the following items. Remember to bring you completed questionnaire to you next visit.

How much have you been troubled by the following symptoms? Minimum possible score 1(not at all) Maximum score is 5 (very much).

	Not at all	A little	Somewhat	A lot	Very much	Score
Pruritus						
1. Pruritus	1	2	3	4	5	
2. Wheals	1	2	3	4	5	
Swelling						
3. Eyes swelling	1	2	3	4	5	
4. Lip swelling	1	2	3	4	5	
Impact on life activities						
5. Urticaria interferes with my work	1	2	3	4	5	
6.Urticaria interferes with my physical activities	1	2	3	4	5	
7.Urticaria interferes with my sleep	1	2	3	4	5	
8.Urticaria interferes with my spare time	1	2	3	4	5	
9.Urticaria interferes with my social relationships	1	2	3	4	5	
10.Urticaria interferes with my eating behavior	1	2	3	4	5	
Sleep Problems						
11.Do you have difficulties in falling asleep?	1	2	3	4	5	
12.Do you wake up during the night?	1	2	3	4	5	
13.Do you feel tired during the day because of your bad night sleep?	1	2	3	4	5	
14.Do you have difficulties in keeping concentration?	1	2	3	4	5	
15.Do you feel nervous ?	1	2	3	4	5	
Limits						
16.Do you feel in a bad mood?	1	2	3	4	5	
17.Do you have to put some limit in choosing food?	1	2	3	4	5	
18.Does urticaria limit your sport activities?	1	2	3	4	5	
Looks						
19.Are you troubled by drugs' side effects?	1	2	3	4	5	
20.Are you embarrassed due to urticaria symptoms?	1	2	3	4	5	
21.Are you embarrassed in going to public places?	1	2	3	4	5	
22.Do you have any problems in using cosmetics?	1	2	3	4	5	
23.Do you have any limits in choosing clothes material?	1	2	3	4	5	
TOTAL SCORE						

Name _____ Date _____

Allergy, Nasal and Asthma Symptom Score Questionnaire

Have you missed any school/work due to respiratory problems in the last month? **YES NO**

Have you been to any physicians or emergency rooms since your last visit on _____?

Have you been prescribed any new medications since your last visit? **YES NO** If yes, please list _____

Are you currently taking Blood Pressure Medication? **YES NO**

If Yes, which medication? _____

Do you have an up to date Epipen? **YES NO**

If you use a rescue inhaler, how frequently are you using it? _____

Mark an **X** on the scale at the location you think corresponds to the importance of your symptoms.

	None	Trivial	Mild	Moderate	Severe
EYES					
Itching					
Swelling					
Watery discharge					
NOSE/NASAL CONGESTION SCORE					
Itching					
Sensation of fullness, congestion, blockage					
Sneezing					
Discharge or runny nose					
Loss of Smell					
EARS					
Itching					
Popping sensation					
Feeling full/congested					
SINUSES					
Headache, facial pain					
Blowing out thick mucus					
Postnasal drip in back of throat					
Throat clearing					
Hoarseness of voice					
BREATHING					
At awakening or during the day, do you have:					
Wheeze					
Cough					
Sputum Production (coughing up material)					
Shortness of Breath					
Chest tightness					
At night, do you wake up with:					
Wheeze					
Cough					
Sputum production					
Shortness of Breath					
Chest tightness					

ALLERGY DIAGNOSTIC SYSTEMS, INC.

Barry A. Lampl, D.O.

HISTORY SHEET Name: _____

Sex: M / F Age: _____ Birthdate: _____ Occupation: _____

Current Medications: _____

Allergies to Medications: _____

YES	NO	ANIMALS-EXPOSURE
		Cat
		Dog
		Bird
		Horse
		Other

YES	NO	SKIN
		Eczema
		Hives

	FAMILY HISTORY			
	Age	Hayfever	Asthma	Sinusitis
Mother				
Father				
Brother				
Brother				
Sister				
Sister				

YES	NO	LIVING ACCOMMODATIONS
		House
		Apartment
		Basement- damp / dry / carpet / furniture
		Bedding- conventional mattress / waterbed
		Bedroom- carpeting / hardwood

YES	NO	HEATING AND COOLING
		Air Conditioner- central / window
		Furnace- gas / electric / wood burning

YES	NO	MONTHS YOU HAVE SYMPTOMS
		All Months
		January
		February
		March
		April
		May
		June
		July
		August
		September
		October
		November
		December

	OTHER		
	Asthma		Diabetic
	Nasal Polyps		Heart Disease
	Deviated Septum		Glaucoma/Cataracts
	Broken Nose		Beta Blocker Medication
	Sinus Disease		Cortisone
	Pneumonia		Learning Difficulty
	Emphysema		ADHD/Hyperactivity
	Nasal/Sinus Surgery		Smoker
	Frequent Headaches		Fatigue
	High Blood Pressure		Prior Allergy Shots
	Stomach Disease		Prior Allergy Testing

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Allergy Diagnostic Systems, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health are bills or to conduct health care operation of Allergy Diagnostic Systems, Inc. I understand that diagnosis or treatment of me by Dr. Barry Lampl or his staff may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Allergy Diagnostic Systems, Inc. is not required to agree to the restrictions that I may request. However, if Allergy Diagnostic Systems, Inc. agrees to a restriction that I request, the restriction is binding on Dr. Barry Lampl and his staff

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Barry Lampl or his staff has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Allergy Diagnostic Systems, Inc. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and has disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Allergy Diagnostic Systems Inc. The Notice of Privacy Practices also describes my rights and Allergy Diagnostic System's duties with respect to my protected health information.

Allergy Diagnostic Systems, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail.

_____

Signature of Patient or Representative

_____ _____

Name of Patient Date