



**Thank you for scheduling with The HFM Zone!** We would like to give you an overview of what you can expect at your initial visit with us.

The HFM Zone is a one-year wellness program focused on health, fitness, and motivation. This is where you come to assess your health and work to prevent serious chronic illnesses that are more common as we age, such as: heart disease, diabetes, or cancer. Individual goals will be set and together we will work toward reaching those goals. What sets The HFM Zone apart from other medical practices is our concentration on wellness.

Unlike traditional doctor visits, which are generally very short, the initial The HFM Zone appointment will be extensive and lengthy. Your visit will last approximately two and a half to three hours. It will include a consultation with Dr. Holden, during which you will discuss your previous medical history, any current health concerns, and he will listen to goals you would like to reach within this year long program.

After seeing Dr. Holden, you will have the following tests performed:

**Bioscan** – A full body scan that shows body fat and muscle mass percentages to get an understanding of your body's composition. We will use this as the starting point and do this test again over the next 1 year to verify your body's composition is changing.

**Antioxidant Screen** – This test measures antioxidants, the first line of defense against disease. It will show your personalized Skin Carotenoid Score, which is a general indication of your overall antioxidant status. We will do this test again over the next 1 year to verify your anti-oxidant score is improving.

**Bio-Energy Testing** – Bio-Energy Testing involves the use of a device connected to a computer that is able to measure how much oxygen the body uses and how much carbon dioxide the body is producing at a given time. A series of measurements are taken at rest and during a progressively more difficult exercise program. This test will tell us your resting and maximal mitochondrial efficiency and your resting and maximal fat metabolism.

**EKG** – This is a noninvasive test that is used to reflect underlying heart conditions by measuring the electrical activity of the heart. Information about many heart conditions can be learned by looking for characteristic patterns on the EKG.

**\*\*You will also have comprehensive labs drawn. These lab tests will require you to be fasting for 10-12 hours. \*It is ok to drink water and take meds the morning of testing. \* Please drink lots of water the day before so you will be well hydrated.**

**Please wear comfy clothes to your appointment. Also, please avoid wearing any metal on clothing, and no jewelry. (This will save a little bit of time in the process.)\*\***

**It will be necessary for you to read, complete, and return all paperwork we have included in this packet.**

We will schedule your follow-up appointments at each visit. Dr. Holden will see you back in two weeks to discuss all your test results. You will receive his recommendations and treatment plan at this time. How often you are seen after this will depend on what treatment is recommended. *For instance, patients focusing on weight loss will be seen more often than patients being seen for hormone replacement therapy.* You will alternate seeing Dr. Holden and Amy Gibbens –Nurse Practitioner every other visit. At this point, you can then decide to continue with us or take his recommendation with no further commitment.

When you approach the end of your first year, you will be offered the opportunity to extend your commitment for another year. **We will collect the Yearly Scan Fee at that time.** Should you decide to continue, a complete re-evaluation will be done. We will see how close you are to meeting your goals. We will perform another full body scan and antioxidant screening, along with a complete physical. These results will be side by side with those from your first visit. With a re-evaluation, we can determine how to proceed as we continue your journey to great health.

**We look forward to seeing you soon!**



## Appointment Checklist

To ensure proper check-in, we have designed this checklist to help you remember what time to check-in and what to bring with you to your first HFM Zone appointment.

**\*\* Arrive 30 Minutes Early for Check-In \*\*** Check-In Time: \_\_\_\_\_ am

**\*\* All Zone Paperwork MUST be Completed and Brought to Appointment**

**This paperwork is vital to this first visit and must be completed ahead of time \*\***

Come Fasting 10-12 Hours (nothing to eat or drink besides water)

Please take all prescription meds as normal but hold vitamins and supplements the day of only.

Bring Your Photo ID and Insurance Card/Cards

Have Your Zone Payment of \_\_\_\_\_ Ready at the Time of Service

Sign up for Our Patient Portal and join our Facebook Group

(For quicker/easier access, please sign up for our HFM Patient Portal. You can request appointments and leave messages all through the easy-to-use patient portal.)

\*Just go to [harrisonvillefamilymedicine.com](http://harrisonvillefamilymedicine.com) and the link to sign up is in the top right corner.\*

To join our HFM Zone Facebook Group, please go to <https://www.facebook.com/groups/144549953031155>.

**\*\* Please give us a call if you have not received your paperwork packet before your visit. If the paperwork is not completed by check-in time, your appointment MUST be rescheduled. \*\***

We can't wait to see you at your appointment!

Please give us a call at (816) 380-3582 if you have any last minute questions!



## HFM Zone Financial Agreement

*Thank you for choosing The HFM Zone for your health care needs. We are committed to providing the best possible care. Please understand that management of your billing is important in ensuring that we can continue to take care of your health care needs. Please read the following information carefully and sign where noted below.*

By executing this agreement, you are agreeing to pay for all services that are received.

**Many of the labs and tests done as part of the Zone program are for screening purposes. These tests are NOT considered medically necessary and therefore may not be covered by your insurance.**

The \$750 yearly program fee must be paid in full by the date of service, or you can set up a monthly payment plan. Payments may be arranged but must be paid in full within 3 months of starting the program. If a balance occurs and is not paid at the time of visit, future visits will not be scheduled until the balance is paid in full.

***By signing this agreement, I understand that I am completely and fully responsible to pay any balance that my insurance company may leave to my responsibility and future visits will not be scheduled until the balance is paid in full.***

***If there are any charges not covered by Medicare or Medicare replacement policies, I understand that I am completely and fully responsible to pay any amount that may be left to my responsibility.***

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Harrisonville Family Medicine, Inc.

### Financial Policy

Effective Date: 7/1/2019

Thank you for choosing Harrisonville Family Medicine as your healthcare provider. Please read the following information carefully. This is an agreement between Harrisonville Family Medicine, Inc., as creditor, and the patient / debtor / responsible party. By executing this agreement, you are agreeing to pay for all services that are received.

**Contracted Insurance:** You are expected to pay deductibles and co-payments at the time of service. You must also pay outstanding balances prior to being seen in the office. **If you are not able to resolve an outstanding balance or pay the copay due before your next appointment, please be aware that your appointment will need to be rescheduled until your balance is paid in full or reasonable payment arrangements are made. If your appointment is rescheduled due to non-payment at time of check in there will be a \$40 no show fee applied.** The deductible will be collected until your yearly deductible has been reached. It is your responsibility to know what is and what is not covered under your plan. It is the insurance company that makes the final determination of your eligibility and coverage. **You will be responsible for any and all charges not covered by your insurance company.**

**Self-Pay Patients:** Payment is expected at the time of service. If you cannot pay at the time of service, your appointment will be rescheduled.

**Monthly Statements:** If you have a balance of \$10.00 or more on your account, we will send a monthly statement. **Please remember when you receive our statement you have already received quality care from your physician, your insurance has been filed and any payment or adjustment from your insurance company has been applied. The balance on your account is due and payable when the statement is issued.**

**Past Due Accounts:** Balances that remain on your account past 45 days are considered overdue and full payment will be expected at future appointments unless a payment plan has been arranged and approved by our billing department. Accounts over 90 days in arrears will be sent to our collection agency. At that point, for any new charges to be added to your account our office will require a credit card on file. Once an account has been placed in collections, the physician/patient relationship could be terminated, and your records will be transferred to a physician of your choice. If your balance is paid after termination has taken effect, reinstatement will involve a fee of \$25. **If a balance occurs on the account again, this will result in FINAL TERMINATION and reinstatement will not be an option.**

**Forms & Fees:** Your portion of any form must be filled out completely before submitting it to us. A fee will be charged and collected when your form is returned to you or submitted on your behalf.

**No Show Policy:** A \$40 fee will be charged for any missed appointment without 24-hour notice. This is not covered by insurance and must be paid prior to your next appointment. Multiple no shows in any 12-month period could result in termination from our practice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

As a courtesy, to our HFM Zone patients, the following policy will become effective September 2, 2013

## THE HFM ZONE

### Late Appointment /Cancellation / No Show Policy

1. Late Appointments

We understand delays can happen, however, we must try to keep other patients and the doctor on time. If you arrive 10 minutes past your scheduled time, we will ask that you reschedule your appointment.

2. Appointment Cancellations

When you do not call to reschedule/cancel an appointment, you are preventing another patient from receiving treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. We ask that you give at least 24 hours in advance notice to reschedule an appointment or for appointment cancellations.

3. No Show Appointments

If your appointment is not cancelled AND you have previously "no showed" more than one appointment, you will be charged a fifty dollar (\$50) fee; this will not be covered by your insurance company and must be paid prior to your next appointment.

My signature below indicates that I understand the above cancellation/no show policy for my appointments with Dr. Holden through The HFM Zone program. If I am unable to keep my scheduled appointment, I will reschedule or cancel within 24 hours. If I am a "no-show" appointment more than once, I understand a charge of \$50.00, will be applied to my account.

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Patient Signature

Date

**\*\*Please review and update the information below to the best of your ability.\*\***

**Patient Registration**

**CURRENT PATIENT INFORMATION -- PLEASE PRINT**

**Guarantor Information (to whom statements are sent)**

Last Name:  
First Name:  
Middle Name:  
Address:  
City: State:  
Zip:  
Home Phone:  
Work Phone:  
Mobile Phone:  
Sex:  
Date of Birth:  
Social Security No.:  
Patient email:  
Required by government mandate [although you may refuse]:  
Language: i  
Race:  
Ethnicity:  
Marital Status:

Name:  
Address:  
Relationship to patient: \_\_\_\_\_  
Date of Birth:  
Social Security No.:  
Phone: ( ) \_\_\_\_\_

**Emergency Contact Information**

Name:  
Relationship:  
Phone:  
Mobile Phone: ( ) \_\_\_\_\_

**Employer Information**

Employer:  
Address:  
Phone:

**Pharmacy Information:**

Name:  
Crossroads:  
Phone:

**Primary Insurance Information**

**Secondary Insurance Information**

Insurance Plan Name:  
Last Name:  
First Name:  
Middle Name:  
Address:  
City: State: Zip:  
Date of Birth: Sex (please circle): **M** or **F**  
Employer Name:  
Patient's relationship to policy holder:

Insurance Plan Name:  
Last Name:  
First Name:  
Middle Name:  
Address:  
City: State: Zip:  
Date of Birth: Sex (please circle): **M** or **F**  
Employer Name:  
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Please sign and date each item below\*\***

**ACKNOWLEDGEMENT AND AUTHORIZATION:**

- I have read and understand the HIPAA/Privacy Policy for HARRISONVILLE FAMILY MEDICINE INC

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I authorize HARRISONVILLE FAMILY MEDICINE INC to release medical information required to process my claim

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I have read and understand the Financial Policy for HARRISONVILLE FAMILY MEDICINE INC

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I authorize HARRISONVILLE FAMILY MEDICINE INC to obtain/have access to my medication history

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I authorize my provider's office to contact me by mobile phone

Signed \_\_\_\_\_ Date: \_\_\_\_\_

**Harrisonville Family Medicine, Inc,**  
**Privacy Consent Form**

(Check all that apply)

\_\_\_\_\_ Myself

\_\_\_\_\_ Spouse: \_\_\_\_\_

Family Member:

\_\_\_\_\_ ALL Adult Family Members

\_\_\_\_\_ ONLY: \_\_\_\_\_

\_\_\_\_\_ Parent or Family Member ( For Minor Child)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

\_\_\_\_\_ May leave a detailed message on answering machine / voicemail

\_\_\_\_\_ NO Details on answering machine / voicemail – Only to call office

\_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_ Consent to text (i.e. appt reminders, office closure due to weather or holidays, etc.)

\_\_\_\_\_ Other: \_\_\_\_\_

**Note: It is your responsibility to notify HFM of any changes that need to be made to this form.**

I acknowledge that by signing below, that I authorize Harrisonville Family Medicine, Inc. to disclose any information related to my / my child's care, with the choices I have indicated above. I also acknowledge that I have received and read a copy of HFM Notice of Privacy Practices.

\_\_\_\_\_  
Patient / Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness



# Past Medical History Form

<b><u>Gastrointestinal</u></b>	<b><u>Social History</u></b>	<b><u>Past Surgical History</u></b>
Ulcer _____	<b>Smoking Status:</b>	<b><u>Cardiovascular</u></b>
Colon Polyps _____	Current _____	Aneurysm Repair _____
Colon Infections _____	How Often? _____	Heart Bypass Surgery _____
Diverticulosis _____	Former _____	Carotid Artery Surgery _____
Diverticulitis _____	Quit Date? _____	Heart Valve Replacement _____
Acid Reflux _____	Never _____	Pacemaker _____
Hepatitis _____	Alcohol Use _____	Defibrillator _____
Liver Disease _____		Stent Placement _____
Irritable Bowel _____	<b><u>Male</u></b>	<b><u>Musculoskeletal</u></b>
Crohn's _____	Elevated PSA _____	Hip Replacement _____
	Erectile Disorder _____	Knee Surgery _____
<b><u>Endocrine</u></b>	Prostate Enlargement _____	Knee Replacement _____
Elevated Thyroid Levels _____		Shoulder Surgery _____
Low Thyroid Levels _____	<b><u>Female</u></b>	Rotator Cuff Repair _____
Diabetes Type I _____	LMP _____	Carpel Tunnel _____
Diabetes Type II _____	Last Pap Smear _____	Lower Back Surgery _____
<b><u>Pulmonary</u></b>	History of Abnl Paps _____	Neck Surgery _____
Environmental Allergies _____	# of Pregnancies _____	<b><u>Genitourinary</u></b>
Chronic Lung Disease _____	Contraception _____	Kidney Removal _____
Chronic Bronchitis _____	Sexually Active _____	Kidney Stone Surgery _____
Chronic Sinusitis _____		Vasectomy _____
Asthma _____	<b><u>Personal History of Cancer</u></b>	Prostate Surgery _____
Sleep Apnea _____	Brain Cancer _____	<b><u>Gastrointestinal</u></b>
<b><u>Musculoskeletal</u></b>	Thyroid Cancer _____	Appendectomy _____
Low Back Pain _____	Breast Cancer _____	Gallbladder Removal _____
Gout _____	Colon Cancer _____	Colectomy _____
Rheumatoid Arthritis _____	Lung Cancer _____	Colostomy _____
Osteoporosis _____	Prostate Cancer _____	Ileostomy _____
Osteoarthritis _____	Leukemia _____	Weight Loss Surgery _____
Fibromyalgia _____	Lymphoma _____	Hemorrhoid Surgery _____
<b><u>Cardiovascular</u></b>	Ovarian Cancer _____	Pancreas Surgery _____
Coronary Artery Disease _____	Cervical Cancer _____	Spleen Removal _____
Atrial Fibrillation _____	Uterine Cancer _____	<b><u>Hernia Repair</u></b>
Previous Heart Attack _____	Kidney Cancer _____	Incisional _____
Elevated Blood Pressure _____		Inguinal _____
Hyperlipidemia _____	<b><u>Family Medical History</u></b>	Umbilical _____
Blood Clot _____		Abdominal _____
Congestive Heart Failure _____	<b><u>Relationship</u></b>	<b><u>Other</u></b>
<b><u>Genitourinary</u></b>	Heart Attack _____	Lung Surgery _____
Kidney Stones _____	High Blood Pressure _____	Thyroid Surgery _____
Chronic Kidney Disease _____	Heart Disease _____	Cataract Surgery _____
Urinary Tract Infections _____	Heart Failure _____	Ear Tubes _____
<b><u>NeuroPsych</u></b>	Blood Clots _____	Tonsillectomy _____
Seizure Disorder _____	Asthma _____	Adenoidectomy _____
Stroke _____	Chronic Lung Disease _____	
Attention Deficit Disorder _____	Cancer _____	
Depression _____	Type: _____	
Anxiety _____	Diabetes _____	<b><u>OB/Gyn</u></b>
Dementia _____	Depression _____	Total Abd. Hysterectomy _____
Alzheimer's _____	Anxiety _____	With Ovary Removal _____
Bipolar Disorder _____	Mental Illness _____	Vaginal Hysterectomy _____
Migraine Headache _____	Alcoholism _____	Tubal Ligation _____
<b><u>Miscellaneous</u></b>	Alzheimer's _____	Cesarean Section _____
Anemia _____	Seizure Disorder _____	Mastectomy _____
HIV Infection _____	Migraine Headaches _____	Lumpectomy _____
Glaucoma _____	Stroke _____	Breast Augmentation _____
	Kidney Disease _____	Breast Reduction _____

## THE HFV ZONE

Name: \_\_\_\_\_

Appointment: \_\_\_\_\_

**Health History**

Circle all that apply

- High blood pressure
- Heart attack
- Heart stent
- Heart bypass surgery
- Atrial fibrillation
- Aneurysm
- Peripheral arterial disease
- Carotid artery disease
- Stroke/TIA
- High cholesterol
- Diabetes
- Sleep apnea
- Depression
- Anxiety
- Chronic kidney disease
- Auto-immune disease
- Blood clots
- Liver disease

- Breast cancer
- Ovarian cancer
- Prostate cancer
- Colon cancer
- Endometrial cancer
- Other cancers:
- Irritable bowel
- Interstitial cystitis
- Fibromyalgia
- Migraine headaches
- Reflux
- COPD
- Asthma
- Other:

- Surgeries:
- Gallbladder
  - Appendix
  - Cataracts
  - Sinus
  - Thyroid
  - Shoulder surgery
  - Knee surgery
  - Low back surgery
  - Neck surgery
  - Hip surgery
  - Hysterectomy
  - Do you still have ovaries? Y/N
  - Mastectomy
  - Carpal tunnel
  - Bariatric surgery

Social

Smoking: current past never

Alcohol: none / occasional / daily

Testing: Please provide date or approximate if unknown

Colonoscopy \_\_\_\_\_ Mammogram \_\_\_\_\_ Bone density \_\_\_\_\_ Pap Smear \_\_\_\_\_

Echocardiogram \_\_\_\_\_ Stress Test \_\_\_\_\_ PSA \_\_\_\_\_ Carotid Doppler \_\_\_\_\_

Family History: circle all that apply

Colon cancer

Heart disease

Diabetes

Alzheimers/dementia

Parkinson's disease

Prostate cancer

Breast cancer

Mental illness

Other:

## THE HFM ZONE

### Intake Form

#### Symptoms

Fatigue	Y/N	Do you get up at night to urinate?	Y/N
Excessive daytime sleepiness	Y/N	Pain on urination	Y/N
Cold hands/feet	Y/N	urinary incontinence	Y/N
Cold Intolerance	Y/N	Recurrent urinary infections	Y/N
Decreased body temperature	Y/N	Trouble with starting or stopping stream	Y/N
Chest pain	Y/N	Joint pains	Y/N
Shortness of breath	Y/N	Muscle aches	Y/N
Heart palpitations	Y/N	Muscle cramp	Y/N
Leg pain with activity	Y/N	Muscle weakness	Y/N
Swelling in legs	Y/N	Muscles decreasing in size	Y/N
Fluid retention	Y/N	Low back pain	Y/N
Puffy face in morning	Y/N	Hip pain	Y/N
		Leg aches	Y/N
		Knee pain	Y/N
		Shoulder pain	Y/N
Heartburn	Y/N		
Bloating	Y/N		
Nausea	Y/N	Acne	Y/N
Constipation	Y/N	Dry skin	Y/N
Diarrhea	Y/N	Thin/brittle fingernails	Y/N
		Thickened skin, especially heels	Y/N
Trouble sleeping	Y/N	Dry or thinning hair	Y/N
Do you snore?	Y/N	Loss of or thinning eyebrows	Y/N
Do you stop breathing at night?	Y/N	Hair Loss	Y/N

## THE HFM ZONE

### Symptoms (continued)

Decreased concentration	Y / N	Hot Flashes	Y / N
Memory concern or loss	Y / N	Night sweats	Y / N
Dizziness	Y / N	Decreased libido/sex drive	Y / N
Headaches	Y / N	Breast tenderness	Y / N
Numbness in arms/legs/feet/hands	Y / N	Excessive facial or body hair	Y / N
Tingling in arms/legs/feet/hands	Y / N	Vaginal dryness	Y / N
		Regular menses	Y / N
Depressed mood	Y / N	Irregular menses	Y / N
Anxiety	Y / N	Mid-cycle bleeding	Y / N
Agitation	Y / N	Heavy menstrual bleeding	Y / N
Feeling nervous	Y / N	Post-menopausal	Y / N
Racing thoughts	Y / N	Fibrocystic breasts	Y / N
Anger	Y / N	Irritable before menses	Y / N
Low self-esteem	Y / N	Emotional before menses	Y / N
Mood swings	Y / N	Weight gain/inability to lose	Y / N
Hypersensitive/Overly emotional	Y / N		

Through The HFM Zone program, Dr. Holden's attention will focus on wellness only. Issues addressed within the Zone program will include cardiac risk reduction, diabetes, weight loss, fatigue, motivation, nutrition and exercise, along with bio-identical hormone replacement therapy.

It is important for you to have a primary healthcare provider who will oversee your primary care and any acute health issues. Typical acute or primary health issues may include: sinusitis, bronchitis, asthma, low back pain, knee pain, flu symptoms, stomach virus. You should contact or schedule with your primary care provider for any "traditional" healthcare needs.

Tell us, who is your primary healthcare provider? \_\_\_\_\_





HARRISONVILLE FAMILY MEDICINE

2820 E. Rock Haven Road, Ste 100

Harrisonville, MO 64701

Phone (816) 380-3582 Fax (816) 380-6964

Patient Name Social Security Number Date of Birth

Releasing records FROM: (physician or organization name)

(mailing address, phone and fax number)

Releasing records TO: (physician or organization name)

(mailing address, phone and fax number)

Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)

Confined to records for the time period of:

Confined to records regarding the specific information:

All records without regard to limitations placed on dates, history of illness, or diagnostic and therapeutic information, including AIDS testing or diagnosis, information or treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness.

For the purpose of:

This authorization is voluntary. This authorization will expire (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I request that records be copied and sent to me that the office will send those records to me within thirty (30) days. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for those costs. I understand that once the requested records leave HFM, they are the responsibility of the patient/recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/recipient will be responsible for providing a flash drive for the electronic copy.

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Relationship to Patient Signature of Witness

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

## Wellness Update

Do you experience any of these symptoms?	Yes	No
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?
<input type="checkbox"/> Occasionally (2-3 times per year)  <input type="checkbox"/> Over 3 times a year  <input type="checkbox"/> A few long periods of time per year (Spring, Summer, Fall, Winter)  <input type="checkbox"/> Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms?  Yes  No

If yes, name of medication and last date taken: \_\_\_\_\_

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years	
<input type="checkbox"/> Sinus related issues (sinus pressure/pain, headaches, sinusitis)  <input type="checkbox"/> Re-occurring Seasonal Colds  <input type="checkbox"/> Chronic colds (lasting longer than 2 months)  <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Restless sleep, challenges sleeping through the night, snoring  <input type="checkbox"/> Consistent or Re-occurring coughing  <input type="checkbox"/> Feeling of fatigue, irritability, & restlessness  <input type="checkbox"/> Asthma  <input type="checkbox"/> Skin conditions (dry and/or Itchy skin, etc...)

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Phone: \_\_\_\_\_

<b>FOR PROVIDER USE ONLY:</b>	
Order Allergy Test: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last ENT exam: ____ / ____ / ____	
Provider Signature: _____	Date: ____ / ____ / ____