Great Lakes Allergy - Buffalo Amherst Allergy

Adult & Pediatric Allergy & Immunology

Jeanne Lomas, DO
Kathleen Donovan, DO
Madeline Lillie, MD PhD
Shivani Raslingam, MD

Christina Long, MPAS PA-C
Allyson Kirk, MPAS PA-C
Eva Raisor, FNP

Phone: 716-631-0380, Fax: 716-836-0773
500 Corporate Parkway, Suite 100
Amherst, NY 14226

Demographic Information

Patient Name: ________________________________ DOB: _________________________

Sex: M F Other: __________________ Preferred Pronouns: ________________________

Patient Address: ____
(Street) (City) (State) (Zip)

Emergency Contact: ____
(Name) (Contact #) (Relationship to patient)

Parent/Guardian: ____
(*if under* 18): (Name) (Contact #) (Relationship to patient)

Primary Care Provider: ______________________________ Phone #: _______________

Race: ☐ White ☐Black/African American ☐AM Indian/Alaska Native
☐Asian ☐Native Hawaiian/Other Pacific Islander
☐Decline ☐ Other: _____________________

Ethnicity: ☐Spanish/Hispanic Origin ☐Not of Spanish/Hispanic Origin ☐ Unknown
☐ Decline

Language: ☐ English ☐Spanish ☐French ☐ Other: _______________

Insurance Information

Primary Insurance: ____
(Name) (Address)

Member ID: _______________________ Group #: _______________________

Subscriber: _______________________ Relationship: _______________ DOB: ______
(Name)

Secondary Insurance: ____
(Name) (Address)

Member ID: _______________________ Group #: _______________________

Subscriber: _______________________ Relationship: _______________ DOB: ______

Prescription Coverage: ____
(Name) (Member ID)

Patient Name: ______________________________ DOB: ________________________

Reason For Visit

What is the main reason you have come to our office:

☐ Asthma/Difficulty Breathing/Coughing
☐ Bee Sting Allergy
☐ Food Allergy
☐ Nasal or Sinus Allergy
☐ Recurrent Infections/Poor Immune System
☐ Skin Issues/Rash
☐ Other: ____

Have you been seen for this problem before?

☐ Yes (Where?) ____
☐ No

Have you had allergy testing before?

☐ Yes (When, where?) ____
☐ No

Have you had any lab tests (Bloodwork)?

☐ Yes (When, where?) ____
☐ No

Have you had any imaging (X-Rays, Sinus CT, Chest CT) done pertaining to your reason for visit?

☐ Yes (When, where?) ____
☐ No

Medications

Are you allergic to any medications?

☐ Yes
    ☐ What Medications/Symptoms? ____
☐ No

Current Medications and Dosages (*Including all over the counter medications and/or herbal supplements*)

____
____
____

Patient Name: ________________________________ DOB: _________________________

Current Medical Problems (*Check all that apply*)

☐ Allergies ☐ Arthritis ☐Asthma ☐ Atrial Fib/arrhythmias
☐ Cancer ☐ Cataracts ☐ Chronic Dry Eye ☐ Contact Dermatitis
☐ COPD ☐Crohn's or Ulcerative Colitis ☐ Diabetes
☐ Eczema ☐ Elevated Cholesterol
☐ EOE (Eosinophilic Esophagitis) ☐ Eustachian Tube Dysfunction
☐ GERD (Acid Reflux/Ulcers) ☐ Hearing Loss ☐ Heart Disease
☐ Hives ☐ Hypertension ☐ Liver Disease ☐ Lupus
☐ Macular Degeneration ☐ Migraines ☐ Nasal Polyps
☐ Psoriasis ☐ Recurrent Ear Infections
☐ Recurrent Pneumonia/Bronchitis ☐ Recurrent Sinus Infections
☐ Recurrent Throat Infections ☐ Skin Disorders ☐ Sleep Apnea
☐Stroke ☐ Thyroid Disease

Previous Surgeries (*Date if known*)

☐ Adenoidectomy _________ ☐ Appendectomy _________
☐ C-Section _________ ☐ Ear Tubes _________
☐ Sinus Surgery: _________ ☐ Tonsillectomy _________
☐ Other (*Date if known*): ______________________________

Previous Hospitalizations/ER Visits for Allergic Conditions (*Asthma, Anaphylaxis*)

____
____

Patient Name: ______________________________ DOB: _______________________

Family Medical History

	Father	Mother	Siblings	Kids
No Known Problems	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Skin Issues/Eczema	☐	☐	☐	☐
Other: ______________	☐	☐	☐	☐

Patient Name: ______________________________ DOB: _______________________

Social History

Are you a current smoker?

☐ Yes

☐ Cigarettes ☐ Marijuana ☐ Vaping

How long: __________________

☐ No

☐ Former smoker?

How old were you when you quit smoking? _______________

Are there any smokers in your home?

☐ Yes

☐ No

Do you have any pets?

☐ Yes

What kind? ___________________________

Do they go into your bedroom? ☐ Yes ☐ No

☐ No

Any mouth breathing or snoring at night?

☐ Yes

☐ No