The William Storms Allergy Clinic

COLORADO SPRINGS CLINIC
1625 Medical Center Point, Suite 190

APPOINTMENT HOURS

Mondays	8:30am – 12:00pm & 2:00pm – 4:00pm
Tuesdays	7:30am – 5:00pm
Wednesdays	8:30am – 12:00pm & 2:00pm – 4:00pm
Thursdays	7:30am –5:00pm
Fridays	8:30am – 1:00pm

SHOT HOURS

Mondays	8:30am – 12:00pm & 1:30pm – 4:30pm *Closed for lunch from 12:00pm–1:30pm*
Tuesdays	8:30am– 6:00pm
Wednesdays	CLOSED
Thursdays	8:30am – 6:00pm
Fridays	8:30am – 1:30pm

Hours are subject to change with inclement weather and/or holidays
Please check www.stormsallergy.com for updates.

SATELLITE CLINICS

BROADMOOR CLINIC ●
218 E. Cheyenne Mountain Blvd
Mon. 8:30pm–4:30pm
Tues. 12:00pm-4:30pm

CORDERA CLINIC ●
9320 Grand Cordera Pkwy, Suite 100
Wed. 8:30-6:00pm

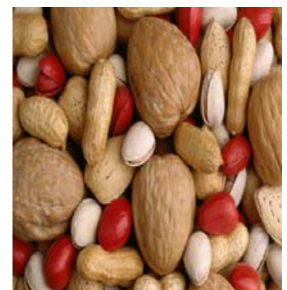
PUEBLO CLINIC ●
900 Indiana Ave, Suite C
Tues. 8:30am–12:00pm & 1:30pm-4:00pm
Wed. 8:30am–12:00pm & 1:30pm-4:*00pm*

LA JUNTA CLINIC ⌘
1100 Carson Ave
(clinical annex next to AVRMC)
Call for details

● ***Appointments & Shots*** ⌘ ***Appointments only***

THIS IS A SCENT-FREE & NUT FREE OFFICE

Please refrain from wearing perfume, cologne, scented oils, scented lotions, body sprays, etc. as this may trigger another patient's asthma.
Also, due to the severity of nut allergies with some patients please do not bring any nuts or nut products into the office.
Thank you for your cooperation.



The William Storms Allergy Clinic

1625 Medical Center Point, Ste 190
Colorado Springs, CO 80907

Tel: 719.955.6000
Fax: 719.955.9595

William W. Storms, MD
Pediatric & Adult Allergy, Asthma, & Immunology

Jill E. Smothers, NP-BC
Kathryn A. Blair, NP-BC
Julia G. Mesnikoff, NP-BC
Carol Halle, NP-BC
Kelly Eskew, NP-BC

900 Indiana Ave, Suite C
Pueblo, CO 81004

Tel: 1-866-615-3885
Pollen report: 719.955.1933

www.stormsallergy.com
www.stormspollen.com

TO OUR NEW PATIENTS:

New patient skin test appointments will take 2 to 3 hours. **Please fill out the enclosed forms and bring them with you. Please check in 20 minutes early.** They are also available on the web at www.stormsallergy.com under forms. There you can open the appropriate form(s), print, fill out and bring in with you. Also, please bring any medical records or other medical information which may be pertinent.

If you are scheduled for SKIN TESTING, please abstain from taking any antihistamines for 72 hours (3 days) prior to your appointment. These medications, and some antidepressants, block allergy skin testing. If you have any questions regarding the identity of your medication, please call us with the names of your medications. You should continue to take ALL OTHER medications, including any asthma medications. **DO NOT STOP ANY ASTHMA INHALERS!**

If your appointment is for a NON-TESTING CONSULTATION, please continue to take all of your medications, including any antihistamines.

If you are not able to keep your appointment, please try to give us at least 48 hours' notice. If you have any questions, please feel free to call our office. We are looking forward to seeing you.

Due to the length of time of this evaluation, we request that children do not accompany the patient to the appointment.

New Patient Information

YOUR PHYSICIAN
Dr. Storms specializes in the treatment of allergy, asthma, and immunology. He is Board Certified by the American Board of Internal Medicine and the American Board of Allergy and Immunology. He is a Fellow of the American Academy of Allergy, and is a Clinical Professor at the University of Colorado Health Science Center.

We also offer you the services of our Masters Prepared, Board Certified Nurse Practitioners, Julia Mesnikoff, Jill Smothers, Kathryn Blair, Carol Halle, and Kelly Eskew.

ALLERGIC DISEASES
We offer complete care of allergic diseases including asthma, hay fever, hives, eczema, insect allergy, selected medication allergy, chronic cough, and recurrent infections including chronic sinusitis and ear infections.

YOUR INITIAL VISIT
A complete evaluation includes a comprehensive allergy history, physical examination, and allergy skin test. Many new patients will have additional tests depending on the nature of their problem, such as breathing tests, sinus CAT scans, or other tests. You could expect to be in the office for approximately 2 to 3 hours. Due to this length of time, we request that children do not accompany the patient to the appointment.

ALLERGY TESTING
Skin testing is the primary way to identify your allergies; if possible, this will be done on the first visit. There are two types of tests which are performed:

- Percutaneous (prick) tests – a skin prick through a drop of allergen on the patient's skin, usually either the back or the forearm.
- Intradermal test – an injection of a small amount of allergen into the skin on the arm.

The number of tests may vary, but usually 65 percutaneous tests are done and 10 to 40 intradermal tests. These tests may be uncomfortable, but they are not painful. The results of the tests are interpreted 20 minutes after they are applied. Please do not apply any moisturizers to your skin before testing!

Because certain medications block allergy skin tests, please do not take any antihistamines or certain tranquilizers without checking with our office at least 1 week before your appointment. If you are not sure of the identity of your medication, please call your pharmacist. Continue to take all other medications according to your doctor's instructions. **Do not stop any of your asthma medications.**

APPROXIMATE CHARGES (*subject to change)*
An initial allergy evaluation may cost up to $1,200, depending upon the extent of the testing required. This cost may include skin tests, pulmonary function tests, and/or sinus CAT scans. This cost does not include allergy treatment, allergy extracts, or additional blood tests.

PRESCRIPTIONS AND REFILLS
First, please call your pharmacy for any and all refills. Call us during regular office hours for problems and questions regarding your prescriptions, but again, refills need to be called to your pharmacy.

CREDIT AND INSURANCE
You should verify with your insurance carrier the specific benefits of your plan. If your insurance company requires a referral to pay for services, please contact your primary care physician to insure that the referral is sent to our office PRIOR to your appointment. Your healthcare insurance company mandates that we cannot see you without a written referral.

The patient financial portion of each visit is the responsibility of the patient. Please check with your insurance company to verify your deductible and co-payment for each visit.

We send out Patient Summaries monthly after we file claims with most insurance companies. You will need to bring your insurance card and a picture ID to your visit. We will collect co-payments, deductibles and co-insurance at the time of your appointment.

PROBLEMS WITH BILLING
Please contact our billing department for any billing questions.

COMPLIMENTS/COMPLAINTS
Please contact our Practice Manager, Shaun Klein, with any compliments and/or complaints you have about your experience in our office. We do want the opportunity to improve and to continue to provide excellent care!

We look forward to meeting you and helping with your medical problems.

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HIPAA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential and absolutely not available to anyone without your expressed written consent. Our medical record of your care remains the physical property of The William Storms Allergy Clinic. The State of Colorado has supported this law. Forms are available to you which will allow you to authorize in writing the release of a copy of specific parts of your medical records to another physician or medical practice. A small fee is charged for making copies and mailing them. Patients who are of age less than 18 years, remain under the legal authority of their parents/legal guardians until emancipated.

Health Care Operations

There remains certain instances where, in the process of delivering good medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical & administrative professionals within this practice, without expressed written permission of each and every specific incident by you. Some examples include:

a. Calling your pharmacy for a renewal of your medication
b. FAXing your pharmacy with a prescription
c. Calling your insurance carrier for billing/reimbursement
d. FAXing your insurance carrier with documentation of care
e. Calling your Primary Care Physician with results of care
f. Writing or FAXing your PCP with questions or results of care
g. Transcription of letters, consults, test results, progress notes, appointment reminders, etc. within the practice
h. Handling of the mail; newsletters, claims, bills, referrals, etc.
i. Requesting that the office/reception staff call you to schedule an appointment, acquire a referral, and discuss medications or behavior preparations prior to or after a medical visit
j. Verbal or written correspondence with insurance companies; yours and ours
k. Discussing (verbal & written) complex evaluation and management of your health with peers and/or experts in medical care
l. Discussing an opportunity to enroll you in ongoing asthma and allergy research; and/or continuation in research studies
m. Routine interoffice communication between professional staff of this specialty practice to effectively manage your medical care, and with the administrative staff to coordinate referrals, send appointment reminders, file & store medical records, order/receive antigen, submit claims and manage accounts, billing, co-pays
n. Etc.

You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law; Federal, State or by Court Order.

Your Right under the Law

1. You have the right to expect that we will respect and honor your personal medical information privacy
2. You have the right to request a copy of your medical record for yourself and/or sent to another physician
3. You have the right to discuss any and all information contained in your medical record with your provider of care in a private environment
4. You have the right to complain to the Practice Administrator on how your medical information is guarded, handled, and released (or not released) under the tenants of the law
5. You have the right to express concerns about the law and its limitations to the U.S. Government Department of Health and Human Services

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "need to know" basis, and then kept confidential for your assurance that we comply with the Federal, State and local laws on "Confidentiality of Medical Information." It is our responsibility to enforce this policy within this practice.

Authorization to Disclose Protected Health Information

The practice may use or disclose your protected health information only with your written authorization. You may revoke authorization.

The practice may use or disclose protected health information about you for other purposes, and without your consent, if the law requires us to disclose information to government authorities. Examples of such uses or disclosures include suspected abuse and infectious diseases.

You have the following rights regarding your protected health information, and the practice must act on your request within 60 days:

- *You may request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction.*
- *You may request that you receive confidential communication of protected health information.*
- *You may request to inspect and copy your own protected health information.*
- *You may request that your information be amended.*
- *You may request a paper copy of this notice.*

The law requires the practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices.

The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions.

You may complain to the practice or to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. File a complaint with the practice by writing to The William Storms Allergy Clinic. No one will retaliate against you for filing a complaint.

The William Storms Allergy Clinic Financial Policy

Thank you for choosing the William Storms Allergy Clinic. Below you will find our financial policy.
Please address questions to 719.955.6000

PAYMENT

Payment is required at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. Acceptable forms of payment are cash, personal checks, VISA, MasterCard, Discover, and American Express. There is a $25 service charge for returned checks. New patients are required to pay 50% of the estimated first visit charges (if applicable according to your benefit plan). The amount is due at time of service in addition to any co-pay, unless you have a Health Savings or Health Reimbursement account. A photo ID of the patient is required. If the patient is a minor, then the parent/guardian will provide their ID.

All patient balances are due in full upon receipt of statement each month unless a formal payment plan is established with the clinic. Any payments received on account will be applied to the oldest balance unless specified by the patient. No patient balance shall be carried for more than 120 days. If my final payment is not received within 120 days, my account may be sent to collections.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay your balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

The William Storms Allergy Clinic may inquire as to my benefits and eligibility on my behalf. I understand that benefits quoted by my insurance to our staff are NOT a guarantee of payment. I will be responsible for any remaining balance that is not covered by my carrier regardless of quoted benefits.

REFUNDS

Patient/guarantor credits in amounts less than $10.00 will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts $10.00 and greater will be automatically refunded to the patient/guarantor. Any refund will be issued no later than 180 days following the appointment to the guarantor on the account. A patient may at any time inquire to the status of their account and request a refund should he or she be entitled to one.

REFERRALS

If I am required to have a referral or authorization for office services, it is my responsibility to get one and maintain it as needed. I understand that if I do not get the required referral or authorization I will be responsible for any charges incurred at my visit.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice. A $50 fee will be assessed at our discretion.

By signing I acknowledge that I have read, understand and agree to this financial policy and authorize assignment of payment directly to the William Storms Allergy Clinic for services provided to me. I also authorize the release of pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Date: ______________________________

Patient Printed Name: ______________________________

Patient Signature: ______________________________
(or legal guardian if patient is a minor)

Revised 8/16

PATIENT REGISTRATION

Please print and complete all parts Chart No:____________________

Have you or any family member been treated by Dr. Storms? ❑Yes ❑No Name: ____________________

PATIENT

Patient Name: ____________________ Age: ____________
Nickname

Race (Circle One): African American Asian Caucasian Mexican American Other: ____________ Ethnicity:__________

Language:____________ Social Security #____________ Maiden/Former Name:____________

Sex: ❑M ❑F Date of Birth:____________ Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Home Address:____________________ Phone:____________

City:____________________ State:________ Zip Code:____________

E-mail Address:____________________

Employer:____________________ Occupation:____________

Employer Address:____________________ Work Phone:____________

City:____________________ State:________ Zip Code:____________

Primary Care Physician: ____________________ PCP Phone: ____________

Address:____________________

How did you hear about our office?: ❑Radio ❑TV ❑ Newspaper ❑Web ❑Phonebook

❑Doctor (____________) ❑NP / PA (____________) ❑Other (____________)

RESPONSIBLE PARTY

Primary Insurance:____________	Secondary Insurance:____________
Address:____________	Address:____________
____________	____________
Phone:____________	Phone:____________
ID#:________ Group#:________	ID#:________ Group#:________
Insured's Name:____________	Insured's Name:____________
Insured's SSN:____________	Insured's SSN:____________
Insured's Birth date:____________	Insured's Birth date:____________
Relationship to Patient:____________	Relationship to Patient:____________
Insured's Employer:____________	Insured's Employer:____________
Employer Address:____________	Employer Address:____________
____________	____________
Employer Phone:____________	Employer Phone:____________
City:________ State:______ Zip______	City:________ State:______ Zip______

Emergency Contact Name:____________________ Phone:____________ Relationship:____________

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand that all charges, co-payments, and deductibles determined to be patient responsibility will be charged to the patient. I authorize payment of insurance benefits directly to The William Storms Allergy Clinic.

As a present or future member of a Health Maintenance Organization (HMO) or other third party payor, I recognize that I may be required by my insurance to get Primary Care Physician's (PCP) referral prior to being treated. If I do not obtain a referral I understand that I am circumventing my health care plan and may be required to pay for services rendered. In such cases, I agree to accept full financial responsibility for charges related to the services rendered without a referral.

❑ I am interested in clinical research studies. I authorize Storms Clinical Research Institute to contact me at:____________________
Phone Number

Signature:____________________ Relationship to patient ❑Self ❑Parent ❑Guardian Date: ____________

HIPAA ACKNOWLEDGEMENT

I have been given and have read the HIPPA informational sheet. I consent to allow The William Storms Allergy Clinic to use or disclose personal health information about me for the purpose of treatment, payment and health care operations in accordance with the above described procedures of health information privacy protection. I further understand my rights under the law as described on the informational sheet.

____ ____

Patient Signature ***Date*** ***(Signature of parent/guardian)*** *If patient is a minor child* ***Date***

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The practice may use or disclose your protected health information only with your written authorization. You may revoke, in writing, authorization at any time. If you choose to restore this authorization, it must be done in writing, on a new form.

I authorize The William Storms Allergy Clinic, to discuss my protected health information with ____________________________;

(Printed name of authorized individual)

______________________________; ________________________; ________; ___________; ____________________

(Address) *(City)* *(State)* *(Zip)* *(Relationship to patient)*

<u>This authorization is good until revoked</u>

____ ____

(Signature of patient authorizing disclosure) *(Signature of staff member; witness to disclosure authorization)*

All of the information on both the front and back of this form is current and correct.
(Please initial and date on the lines provided below)

_____________________ _____________________ _____________________ _____________________

_____________________ _____________________ _____________________ _____________________

_____________________ _____________________ _____________________ _____________________

THE WILLIAM STORMS ALLERGY CLINIC
MEDICAL HISTORY

Date:________________ Name:____ Age:__________

Sex: M___ F____ Occupation:____

In your own words, briefly describe your symptoms and/ or reasons for coming to see Dr. Storms:

____

____

____

LIST YOUR CURRENT MEDICATIONS: **Marijuana: Edible □ Inhalation □**
(including non-prescription & supplements)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

ARE YOUR IMMUNIZATIONS UP TO DATE?
Yes____ No____

ADULT ILLNESS:	**DATE**

OPERATIONS/HOSPITALIZATIONS:	**DATE**

Childhood Illnesses: (check each one you have had)

___measles ___mumps ___rubella ___whooping cough ___rheumatic fever ___polio ___scarlet fever

___asthma ___hay fever ___recurrent croup ___bronchiolitis ___recurrent ear infections ___recurrent sinus infections

List all medications you do not tolerate	Medication:	Reaction:	Date:
	1.	1.	1.
	2.	2.	2.
	3.	3.	3.
	4.	4.	4.

List all foods you do not tolerate	Food:	Reaction:	Date:
	1.	1.	1.
	2.	2.	2.
	3.	3.	3.

Do you smoke? Yes____ No____
If yes, how many packs per day (average)______________
For how many total years? ______________________

Have you ever smoked? Yes____ No____
If yes, for how many total years? ______________
When did you quit? __________________

Are there smokers within the family? Yes____ No____ Do they smoke in the home? Yes____ No____

Do you have any household pets? Yes____No____

Kind of pet:	Number in house:

Name: ______________________________________ **Date of Birth:** _________________

Any history of the following in your family? (Indicate only blood relatives in the space)

Hay fever	Y__ N__	mom dad	other:________________
Asthma	Y__ N__	mom dad	other:________________
Hives	Y__ N__	mom dad	other:________________
Atopic dermatitis (eczema)	Y__ N__	mom dad	other:________________
Chronic sinus problems	Y__ N__	mom dad	other:________________
Nasal polyps	Y__ N__	mom dad	other:________________
Bee allergy	Y__ N__	mom dad	other:________________
Cystic fibrosis	Y__ N__	mom dad	other:________________
Chronic bronchitis	Y__ N__	mom dad	other:________________
Anemia	Y__ N__	mom dad	other:________________
Hypertension	Y__ N__	mom dad	other:________________
Heart disease	Y__ N__	mom dad	other:________________
Arthritis	Y__ N__	mom dad	other:________________
Diabetes	Y__ N__	mom dad	other:________________
Seizure Disorder	Y__ N__	mom dad	other:________________
Cancer	Y__ N__	mom dad	other:________________

Recreational drug use (self only): Y__ N__ ________________

Alcohol servings per week (self only):________________________

REVIEW OF SYSTEMS: Are you currently experiencing any significant problems with:

Constitutional	Weight loss❑ Fever❑ Chills❑ Poor appetite❑ Fatigue❑ Weight gain❑ Insomnia❑ Night sweats❑
Eyes	Blurry vision❑ Eye pain❑ Eye discharge❑ Eye redness❑ Decrease in vision❑ Dry Eyes❑ Double vision❑
ENT	Sore throat❑ Hoarseness❑ Ear pain❑ Hearing loss❑ Nose bleeds❑ Tinnitus❑ Sinus issues❑
Cardiovascular	Chest pain❑ Palpitations❑ Heart murmur❑ Swelling in legs or feet❑
Respiratory	Short of breath❑ Chronic cough❑ Cough up blood❑ Tuberculosis❑ sputum production❑
Gastrointestinal	Nausea❑ Vomiting❑ Diarrhea❑ Constipation❑ Blood in the stool❑ Frequent heartburn❑ Trouble swallowing❑
Genitourinary	Urinary frequency❑ Blood in the urine❑ Incontinence❑ Painful urination❑ Urinary retention ❑Frequent UTIs❑
Skin	Hair loss❑ Skin sores/ulcers❑ Itching❑ Skin thickening❑ Nail changes❑ Mole changes❑
Musculoskeletal	Joint pain❑ Frequent leg cramps❑ Muscle weakness❑ Bone pain❑ Joint swelling❑ Back pain❑
Psychiatric	Anxiety❑ Depression❑ Alcohol/drug dependence❑ Suicidal thoughts❑ Use of anti-depressants❑
Endocrine	Goiter❑ Heat intolerance❑ Cold intolerance❑ Increased thirst❑ Change in skin pigment❑
Neurological	Seizures❑ Migraines❑ Numbness❑ Dizziness/Vertigo❑ Loss of balance❑ Stroke❑
Hem/Lymphatic	Easy bruising❑ Swollen lymph nodes❑ Transfusions❑ Prolonged bleeding❑ Blood clots❑
Allergic/Immun	Allergic reactions❑ Frequent infections❑ Hepatitis❑ HIV positive❑ Positive PPD❑

Have you had a previous allergy evaluation (testing)? Yes____ No____

Date	Doctor Name & City	Result
______________	____	____________________
______________	____	____________________

Did you take allergy injections? Yes___ No___ How long?________________ Did they help? Yes___ No___

Did you have any reactions to the shots? Yes___ No___ Please explain:________________________

How long have you lived in Colorado?____________________ Where did you live before?____________________

Do you live in a single dwelling, apartment, mobile home, or other?________________________________

How old is your home?________________ How long have you lived there?________________________

What type of heating system is in your home?____

Do you have an air filter in your home? Yes___ No___

Is there any other medical information not indicated on this form?________________________________

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

______________________________ ____________ ______________________________ ____________

Patient Signature Date (Signature of parent/guardian) If patient is a minor child Date

Any changes? Y___ N___ Explain:____ Date:__________ Init______

Any changes? Y___ N___ Explain:____ Date:__________ Init______

Any changes? Y___ N___ Explain:____ Date:__________ Init______

Any changes? Y___ N___ Explain:____ Date:__________ Init______

THE COUGH CENTER
at The William Storms Allergy Clinic

Patient Name:____ Date:________________________

Please fill this out as well as you can; it will help us in finding the cause of your problem.

1. Do you or have you smoked or chewed tobacco? ___Y ___N
   a. How many years?_____ b. About how many packs per day, average?_____

2. Have you been exposed to secondhand smoke? ___Y ___N How many years?_____

3. Have you been diagnosed as having:
   ___asthma ___chronic bronchitis/COPD/emphysema ___other lung disease
   a. How was the diagnosis made?____
   b. What treatment was given?____

4. When was your last chest X-Ray?______________________ Was it normal? ___Y ___N

5. Is your cough: wet?___ dry?___ bloody?___
   a. If wet, how much mucus do you bring up each day?____
   b. Does anything/anyplace make your cough worse?_______________ better?____________

6. What treatments have been prescribed for your cough?
   a. Inhalers? ___Y ___N name?____
   b. Pills? ___Y ___N name?_
   c. Other?____

7. Have you been taking pills for high blood pressure or heart disease? ___Y ___N
   a. If so, what?____

8. Have you ever had stomach acid reflux, GERD, hiatal hernia, etc? ___Y ___N
   a. Were you treated? ___Y ___N With what?______________________ Did it help? ___Y ___N

9. Have you had postnasal drip (sinus drainage down the throat)? ___Y ___N

10. Have you had nasal allergies/hay fever? ___Y ___N

11. Is there a history in your family (blood relatives) of:
    a. Asthma ___Y ___N If yes, who?______________________________
    b. COPD/Emphysema ___Y ___N If yes, who?______________________________
    c. Cystic fibrosis ___Y ___N If yes, who?______________________________
    d. Interstitial lung disease ___Y ___N If yes, who?______________________________
    e. Other lung disease ___Y ___N If yes, who?______________________________

12. Check any following you've been exposed to:
    __Silos on farms __Car spray paint __Wood-working __Birds/chickens __Soldering

LIST ALL PRIOR MEDICATIONS FOR COUGH:

Name of medication and date received	Helpful	Not helpful