



Follow Up Visit Medication Update

Please write down your medications, including inhalers, nasal sprays, as needed medications, over the counter medications and vitamins.

Patient Name _____ Date of Visit _____

Pharmacy Name & Phone Number _____ (____) _____

Drug Allergies _____

Allergy and/or Asthma medications (check the following where appropriate)

Name of Medication	mg	Frequency	Daily	As Needed	Need Refill	Need 90 day mail in Prescription

Do you use an aerochamber/spacer with any inhalers? Yes No **Which Inhaler(s)?** _____

Nasal saline irrigation as needed once daily twice daily

What device do you use? Ocean spray fine mist bottle Sinus Rinse Water Pik device other _____

Other Medications

Name of Medication	Dose	Frequency

Do you have an Epi-pen? : Yes No Current Expired

Allergy Injections: received in this office other medical facility: **Where** _____

Phone # _____

Frequency of injections: twice weekly weekly every 2 weeks every 3 weeks once monthly

IV / Subcutaneous Gammaglobulin: once weekly every 3 weeks

Over The Counter Medications

Name of Medication	Dose	Frequency

Vitamins and Supplements

Name of Vitamin	Dose	Frequency



Annual Information Sheet
Robyn J. Levy, M.D., FAAAAI, Board Certified ABAI

PLEASE FILL IN ALL SPACES AND SIGN AND DATE AT THE BOTTOM

Patient Information

Referred By _____
Personal Physician _____ Phone # _____ Fax # _____

PATIENT NAME: _____
FIRST MIDDLE LAST NAME CALLED

HOME ADDRESS _____

CITY _____ STATE _____ COUNTY _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ **AGE** _____ MALE FEMALE

EMPLOYED BY _____

OCCUPATION _____

BUSINESS PHONE _____

SPOUSE'S NAME _____

SPOUSE'S HOME PHONE _____

SPOUSE'S EMPLOYER _____

SPOUSE'S OCCUPATION _____

SPOUSE'S BUSINESS PHONE _____

I authorize Family Allergy & Asthma Center, P.C., to fax my medical information to me at the following fax #:

Home Work _____ Initials: _____

I authorize Family Allergy & Asthma Center, P.C., to send appointment confirmations/ reminders to the following e-mail address:

_____ Initials: _____

I decline receiving any of my medical information or communication via fax or e-mail. Initials: _____

EMERGENCY CONTACT (not in household) _____ **RELATIONSHIP** _____ **PHONE** _____

INSURANCE INFORMATION

Insurance Company	Subscriber Name	Policy # or Certificate #
1. Primary _____	_____	_____
2. Secondary _____	_____	_____

FINANCIAL RESPONSIBILITY

RELATIONSHIP TO PATIENT: (Circle one) **SELF PARENT GUARDIAN**

RESPONSIBLE PARTY _____ **HOME PHONE** _____

IF PATIENT IS A DEPENDENT:

FATHER'S NAME _____ **HOME PHONE** _____

FATHER'S EMPLOYER _____ **BUSINESS PHONE** _____ **OCCUPATION** _____

MOTHER'S NAME _____ **HOME PHONE** _____

MOTHER'S EMPLOYER _____ **BUSINESS PHONE** _____ **OCCUPATION** _____

I, _____ authorize medical staff of Family Allergy & Asthma Center, P.C., to treat me/my child for medical conditions covered by their specialty & scope, including testing & treatment of emergency conditions and transfer to a hospital if medically necessary.

SIGNATURE OF PATIENT, GUARDIAN, OR RESPONSIBLE PARTY

DATE