Name:___________________________
DOB:___________________________
Primary Allergist:__________________

AAA Alliance Care Welcome Letter

Welcome to Arizona Asthma and Allergy Alliance Care. We strive to provide comprehensive care for many medical conditions you have as well as help you enhance your overall health, wellness, and wellbeing. Before your visit, please complete this form online or in our office. During your visit a general health and wellness assessment will be done. It is important to consider your mind, body and spirit as we develop a plan for your optimal health. Completing these questions will help guide your providers to the areas of concern, so an appropriate treatment plan can be developed for your care.

Your health concern(s) are:

1)

2)

3)

List any past alternative treatments you have tried, for these concerns and for what duration of time. Did you feel they were helpful, no change, or worsened the problem?

1)

2)

3)

List all vitamins, minerals, herbal medicines or other nutritional supplements you are taking now and why? Please include the dosage and date started Ex: 1 capsule daily 1/2014

1) 4)

2) 5)

3) 6)

When was the last time you felt well? How would you rate your health today on a scale of 1-5?

Your health goal(s) are:

1)

2)

3)

Is there any activity you used to do that you would like to restart or something new you would like to try?

List the names of other health care providers involved in your care

1)

2)

3)

Health questions:

In the last year, how many days did you miss from work/school due to your health?

Do you have allergies/sinus problems? Do you feel they are controlled?

Do you have asthma? Do you feel it is controlled?

Do you have recurrent or chronic infections?

Do you have skin problems such as eczema, hives, rosacea, or acne?

Do you have headaches or migraines?

Do you have thyroid disease? Does anyone in your family have thyroid disease?

Do you have difficulty losing weight?

Do you have heart, liver or kidney disease?

Do you currently use tobacco? If so, would you like to quit?

What are your interests and hobbies? How often do you engage in these activities per week or month?

Rate your stress level 1-5 with 5 being high and what are the major stressors?

Do you feel anxious or depressed? Are you currently being treated or been treated in the past?

What do you do to relax or relieve stress?

Who do you consider to be part of your support system?

During the past month, did you participate in any physical activities or exercise? How often and for how many minutes/hours?

What is your occupation?   How many days in the week do you work?

Are fatigue or tiredness frequent problems for you?

Do you have problems sleeping? How many hours per night do you sleep on average?

Have you been told you snore loudly or stop breathing while you are sleeping?

How important is religion or spirituality for you and your family's life?

Nutrition History:

Do you have food allergies?

Are you currently on a special diet (e.g.: vegan, gluten-free, dairy-free, etc)?

Are there any foods you avoid because they give you symptoms?

Do you feel you digest your food well?

Do you have constipation, diarrhea, bloating, excessive gas or stomach pain?

How many bowel movements do you have a week?

How many meals do you generally eat per day?

Do you skip meals?

Do you drink caffeinated beverages (soda, tea, coffee, energy drinks), if so how many per day or week?

Do you use artificial sweeteners?

How many 8 oz glasses of water do you drink a day?