CONNECTICUT MEDICAL GROUP, LLC
ALLERGY, ARTHRITIS AND INFECTIOUS DISEASES ASSOCIATES
Richard J. Mangi, M.D. M.B.A.
9 Washington Avenue
Hamden, CT 06518

Patient's Name _____ Home Telephone ( ) _____

Address _____ Work Telephone ( ) _____

City _____ State Zip _____ Employer _____

Sex _____ Male _____ Female SS# _____

Date of Birth _____ Marital Status _____ married _____ single _____ divorced _____ widow

Primary Doctor _____ email: _____

Emergency Notification or Next of Kin _____ Telephone ( ) _____

Primary Insurance Co: _____ Policy No. _____

Referral Required Yes _____ No _____

Group# _____ Subscriber Employer _____

Name of Subscriber _____ Relation to patient _____

Subscribers SS# _____ Subscriber's Date of Birth _____

Address _____ City/State/Zip _____

Secondary Insurance Co: _____ Policy No. _____

Referral Required Yes _____ No _____

Group# _____ Subscriber Employer _____

Name of Subscriber _____ Relation to patient _____

Subscribers SS# _____ Subscriber's Date of Birth _____

Address _____ City/State/Zip _____

Are you allergic to any medications? Yes _____ No _____
If yes, please list:

_____

Are you presently taking any medications? Yes _____ No _____
If yes, please list:

_____

I consent to treatment necessary for care of the above name patient.
I authorize the release of all medical records to referring providers and to my insurance company.
I allow fax transmission of my medical records if necessary.
I acknowledge that Connecticut Medical Group is filing a claim to my insurance carrier (if applicable). I agree to pay any part of the portion of this claim which is considered self-pay (if applicable).
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that the insurance payments be made directly to Connecticut Medical Group.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date: _____ Signature _____

RICHARD MANGI, M.D.

ALLERGY AND ARTHRITIS ASSOCIATES
ALLERGY HISTORY

Last Name-First Name	Age Date of Birth	Family Doctor	Who Referred You Here?
Address		Phone Number Home: Work:	How Long Have You Lived in Connecticut?

Major Allergy Problem

What Are Your Allergy Symptoms? (Circle)
Sneezing Runny Nose Itchy Eyes Congestion Cough Wheezing Asthma Headache Scratchy Throat Other

How Long Have You Had This Problem?	What Time Of The Year Are Your Symptoms Most Severe? (Please Circle) Jan Feb March April May June July August Sept Oct Nov Dec

Where Are Your Symptoms Most Severe? (Circle) Home Work Indoors Outdoors Other Environment (Where?)

What Medications Have You Taken For These Symptoms And How Well Do They Work?

Name of Medicine:	Did The Medicine Work?	Did You Have Side Effects? (Please Describe)
	Yes No Some Relief	
	Yes No Some Relief	
	Yes No Some Relief	
	Yes No Some Relief	
	Yes No Some Relief	
	Yes No Some Relief	
	Yes No Some Relief	
	Yes No Some Relief	

What Medications Are You Currently Taking for Your Allergies or Asthma?

Medicine	Dose	Frequency

Are You Allergic To Medications? (List And Describe Reaction)

Are You Allergic To Insect Stings? (Describe Reaction)

What Aggravates Your Symptoms? (Circle)
Dust
Old Leaves
Hay
Lakeside
Cut Grass
Damp Basement
Newspapers
Perfumes
Tobacco Smoke
Wool
Down
Weather Changes
Heat
Air Conditioning
Wine
Beer
Cheese
Other Foods
Animals (Indicate Type)

Have You Ever Had? (Circle and Describe)
Hives
Eczema
Allergic Rash
Food Allergy
Asthma
Wheezing
Persistent Cough
Shortness of Breath During Exercise
Sputum or Phlegm
Bronchitis
Emphysema
Sneezing Attacks
Persistent Running Nose
Post Nasal Drip
Sinus Disease
Sinus Infection
Frequent Headaches
Itchy Eyes
Ear Infections

Allergy, Asthma and Ear Nose and Throat History

Have You Seen An Allergist Before? Yes No
Name of Allergist:

Date Seen:
Skin Test Results:

Did You Receive Allergy Injections? Yes No
For How Long?
Did They Help? Yes No

Have You Seen A Pulmonary Specialist? Yes No
Name:

Have You Had Pulmonary Function Tests? Yes No
Date: Results:

Have You Seen An Ear, Nose & Throat Doctor? Yes No
Name of Doctor:
Date Seen:
Have You Had Sinus Surgery? Yes No
Date of Surgery:
Have You Had A CAT Scan of Your Sinuses? Yes No
When? Results?

Do You Have a Family History of Allergies? Yes No
Do You Have a Family History of Asthma? Yes No

General Health

List All Your Medical Problems:

What Medications Are You Currently Taking?
Medication Dosage

Your Environment

Home

Who Lives With You?	Relation	Age
Name		
Name		
Name		
Name		

How Old Is Your Home?
How Long Have You Lived There?

Is There A Room Where Your Symptoms Are More Severe? (Where?)

Do You Have Any Pets At Home? Yes No
Type of Pets:
Number Of Pets:
Breed:
How Many Years Have You Had Them?
Do They Go Into Your Bedroom? Yes No

Type of Heating:
Hot Air Radiant Wood Stove Other

In Your Bedroom Do You Have The Following?

Down Pillow	Yes	No
Down Comforter	Yes	No
Wall-To-Wall Carpeting	Yes	No
Wool Blanket	Yes	No
Book Shelves	Yes	No
Stuffed Toys	Yes	No

Do You Have The Following In Your Home?

Central Air Conditioning	Yes	No
Bedroom Air Conditioning	Yes	No
Dehumidifier	Yes	No
Damp Basement	Yes	No
Mildew	Yes	No
Houseplants	Yes	No
Cigarette Smokers	Yes	No

Is Your House? (Circle)
Very Dusty
Moderately Dusty
Almost Dust Free

Do Any Family Members Have Hobbies That Produce?
Dust Yes No
Fumes Yes No
Strong Odors Yes No

WORK

Occupation

Place of Employment

How Long Have You Worked There?

Past Occupations

Describe Your Workplace Environment

Is There Anything At Work That Aggravates Your Symptoms?

Hobbies

What Are Your Hobbies?

Are Your Symptoms Better or Worse With Your Hobbies?