ALLERGY & ASTHMA SPECIALISTS OF NORTH FLORIDA, P.A.

(904) 730-4870 ◆ **www.JaxAllergy.com**

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NEW PATIENT QUESTIONAIRRE

Date of first visit: ____ - _____ - _____

Patient Name: _____ _____ _____
Last *First* *MI*

Date of Birth: ____ - _____ - _____ **Age**: _____ **Sex**: ❍ Male ❍ Female

Home Phone: (____) _____-_____ **Cell:** (____) _____-_____ **Work:** (____) _____-_____

Home Address:

_____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

E-mail address: _____

Emergency Contact Name: _____ Phone: (____) _____-_____

Referring Provider:_____ Phone #: (_____) _____-_____

Address: _____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

Primary Provider: _____ Phone #: (_____) _____-_____

Address: _____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

Local Pharmacy: _____ Phone #: (_____) _____-_____

Address: _____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

Mail Order Pharmacy: _____ Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

Address: _____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

How did you hear about us?

❍ Referring Provider ❍ Other patient/friend ❍ Insurance Website ❍ Insurance Book

❍ Yellow Pages ❍ Health Fair ❍ jaxallergy.com ❍ Advertisement

❍ Internet search (e.g. Google, Yahoo) ❍ Other: _____

A. What is the ONE main problem (chief complaint) which caused you to visit us? Please explain in your own words.

B. What other "allergic" problems may we address today? Please list.

C. NASAL ❑ **NONE** *(If none, please check the box and skip to Section D.)*

1. Please check if you have any of the following symptoms:

❑ Runny Nose ❑ Itchy Nose ❑ Nose Rubbing ❑ Frequent Nose Blowing
❑ Sneezing ❑ Stuffiness ❑ Post-Nasal Drip / Drainage ❑ Sniffling
❑ Decreased Smell ❑ Decreased Taste ❑ Snoring ❑ Mouth Breathing
❑ Frequent Nosebleeds ❑ Facial pressure ❑ Nasal Polyps ❑ Discolored Mucus

D. HEADACHE / SINUS ❑ **NONE** ***(If none, skip to Section E)***

1. Where is your pain located?

❑ Forehead ❑ Temples ❑ Mask-Like ❑ Behind Eyes ❑ Cheeks
❑ Back Of Head ❑ Right Side ❑ Left Side ❑ Both Sides

2. What best describes your headache? ❑ Sinus ❑ Migraine ❑ Arthritis ❑ Tension ❑ Stress

3. Triggers? ❑ Bright Lights ❑ Loud Noises ❑ Nasal Congestion ❑ Certain Foods ❑ Stress

4. Do you have any other symptoms with the headaches?
❑ Nausea ❑ Vomiting ❑ Vision Changes

5. What makes your headaches better? _____

6. How many sinus "infections" have you had in the past 12 months that were treated with antibiotics? _____

E. EYES ❑ **NONE** *(If none, please check the box and skip to Section F.)*

1. Please check if you have any of the following symptoms:
❑ Burning ❑ Tearing ❑ Itching ❑ Redness ❑ Eyelid Swelling ❑ Dryness

F. EARS ❑ **NONE** *(If none, please check the box and skip to Section G.)*

1. Please check if you have any of the following symptoms: ❑ Fullness ❑ Popping ❑ Pain
❑ Plugging ❑ Decreased Hearing ❑ Dizziness/Light-Headed ❑ Ringing ❑ Frequent ear infections

G. THROAT ❑ **NONE** *(If none, please check the box and skip to Section H.)*

1. Please check if you have any of the following symptoms: ❑ Itching ❑ Throat Clearing ❑ Hoarseness
❑ Frequent Sore Throat ❑ Voice Changes ❑ Burning ❑ Belching ❑ Indigestion ❑ Heartburn

H. COUGH ❑ **NONE** *(If none, please check the box and skip to Section I.)*

1. Do any of the following make your cough worse? Check all that apply. ❑ Post-Nasal Drip/Drainage
❑ Exertion/Exercise ❑ Laughing ❑ Talking on the Phone ❑ Lying Down ❑ Meals

I. CHEST/BREATHING PROBLEMS ❑ NONE *(If none, please check the box and skip to Section J.)*

1. Have you ever been diagnosed with and/or treated for asthma? ❍ Y ❍ N
2. Have you seen a pulmonologist (lung doctor)? ❍ Y ❍ N
   If yes, whom do/did you see? _____
3. When were you first diagnosed with asthma? _____
4. How have your symptoms changed since that time? ❍ Worse ❍ Better ❍ More Frequent ❍ Same
5. Describe a typical episode. ❑ Chest Tightness ❑ Wheezing ❑ Short Of Breath ❑ Coughing
6. What makes your asthma symptoms better? _____
7. Do you use a rescue inhaler (albuterol)? ❍ Y ❍ N If so, does this relieve your symptoms? ❍ Y ❍ N
8. In an **AVERAGE** week within **PAST 4 WEEKS**, how many times did you use your rescue inhaler? _____
9. Do you wake up at night with asthma symptoms? ❍ Y ❍ N
   If so, how many times in an **AVERAGE WEEK**? _____
10. Do your asthma symptoms limit your activity/exercise? ❍ Y ❍ N
11. Do you feel as if your asthma is under control? ❍ Y ❍ N
12. Have you ever taken steroid pills (Medrol, prednisone, Orapred) for your asthma? ❍ Y ❍ N
    If yes, how many times in the past 12 months? _____
13. How many times in the past **12 months** have you been hospitalized for asthma? _____
    Gone to the emergency room or urgent care? _____
14. Do you have any history of (if applicable)? ❑ COPD ❑ Emphysema ❑ Frequent Pneumonias
    ❑ Fibrosis ❑ Scarring Of Lungs ❑ Other Lung Disease: _____

J. TRIGGERS *** Please place a check in the appropriate box next to trigger if it flares your symptoms. ***

Trigger	*Nose*	*Eyes*	*Chest*	Trigger	*Nose*	*Eyes*	*Chest*	Trigger	*Nose*	*Eyes*	*Chest*
Spring	❑	❑	❑	**Work**	❑	❑	❑	**Emotions**	❑	❑	❑
Summer	❑	❑	❑	**Home**	❑	❑	❑	**Exercise**	❑	❑	❑
Fall	❑	❑	❑	**Odors**	❑	❑	❑	**Nasal allergies**	*N/A*	❑	❑
Winter	❑	❑	❑	**Smoke**	❑	❑	❑	**Heartburn**	❑	❑	❑
Season change	❑	❑	❑	**House dust**	❑	❑	❑	**Foods**	❑	❑	❑
All year	❑	❑	❑	**Mold or mildew**	❑	❑	❑	**Alcohol**	❑	❑	❑
Indoors	❑	❑	❑	**Pollen**	❑	❑	❑	**Aspirin**	❑	❑	❑
Outdoors	❑	❑	❑	**Cats**	❑	❑	❑	**Jacksonville area**	❑	❑	❑
Daytime	❑	❑	❑	**Dogs**	❑	❑	❑	**Away from Jacksonville**	❑	❑	❑
Night	❑	❑	❑	**Other pets**	❑	❑	❑	**Other:** _____	❑	❑	❑

K. SKIN RASHES / ITCHING / HIVES / SWELLING / ANAPHYLAXIS

❑ **NONE** *(If none, please check the box and skip to Section L.)*

1. Please describe your rash/reaction in your own words.

2. Have you seen another physician for your symptoms? ❍ No ❍ PCP ❍ Dermatologist ❍ ER ❍ Urgent Care

   Name of physician(s): _____ Date(s) seen: _____

   What diagnosis was made? _____

3. What medications have you taken/were given for your symptoms?
   ❑ Epinephrine (Epi-pen, Auvi-Q) ❑ Solumedrol (Steroid Shot) ❑ Prednisone ❑ Medrol ❑ Benadryl
   ❑ Albuterol Inhaler/Nebulizer ❑ Hydroxyzine (Atarax/Vistaril) ❑ Claritin (loratadine, Alavert)
   ❑ Allegra (fexofenadine) ❑ Zyrtec (cetirizine) ❑ Clarine ❑ Xyzal (levocetirizine) ❑ Singulair (montelukast)
   ❑ Doxepin (Sinequan) ❑ Zantac (ranitidine)/Pepcid (famotidine) ❑ Other: _____

4. What best describes your rash (check all that apply)?
   ❑ Raised Welts ❑ Small Bumps ❑ Scaly Areas ❑ Blisters ❑ Lines Of Redness
   ❑ Rough Patches ❑ Other: _____

5. What is the size of the each individual lesion?
   ❑ SMALLER than a pea ❑ PEA size ❑ NICKEL size ❑ QUARTER size ❑ HALF DOLLAR size
   ❑ LARGER than half dollar ❑ VARYING sizes

6. Where is the rash located (check all that apply)?
   ❑ Scalp ❑ Face ❑ Neck ❑ Chest ❑ Back ❑ Arms ❑ Groin ❑ Legs ❑ Entire Body

7. When did the rash/reaction begin? _____
   Has it changed since then? ❍ Same ❍ Worse ❍ Better

8. How often do you have it? ❍ Daily ❍ Weekly ❍ Monthly ❍ Yearly ❍ Always ❍ Other _____

9. How long does each individual lesion last? ❍ 1-2 Hours ❍ 3-23 Hours ❍ 1-2 Days ❍ Longer Than 2 Days

10. Does the rash do any of the following? ❑ Itch ❑ Burn ❑ Sting ❑ Hurt ❑ Leave A Bruise

11. Do you have any swelling? ❍ Y ❍ N If yes, where? ❑ Lips ❑ Tongue ❑ Eyes ❑ Hands ❑ Feet

12. Have you had any of the following symptoms associated with the rash?
   ❑ Throat Closing ❑ Trouble Swallowing ❑ Hoarseness ❑ Difficulty Breathing
   ❑ Wheezing ❑ Nasal Congestion ❑ Sneezing ❑ Diarrhea ❑ Cramping ❑ Vomiting

13. Do any of the following produce the hives/swelling/rash?
   ❑ Heat ❑ Showering/Bathing ❑ Exercise ❑ Sunlight ❑ Pressure/Prolonged Sitting
   ❑ Vibration ❑ Friction/Tight Clothes ❑ Rubbing/Scratching ❑ Cold Temperatures

14. What do you think caused/triggered your symptoms? _____

15. Where are your symptoms worse? ❑ Home ❑ Work ❑ Inside ❑ Outside ❑ Stress ❑ Menstrual Periods
❑ Pregnancy ❑ Other: _____

16. What makes your symptoms better? _____

17. Is there any seasonal association to the symptoms? ❑ No ❑ Spring ❑ Summer ❑ Fall ❑ Winter

18. Have you noticed an association with any of the following foods with your symptoms?
❑ Peanuts ❑ Tree Nuts ❑ Shellfish ❑ Other Fish ❑ Milk ❑ Eggs ❑ Wheat
❑ Soy ❑ Tomatoes ❑ Fruits ❑ Preservatives ❑ Coloring/Dyes ❑ Gum/Candy ❑ Meats
❑ Other Foods: _____

19. Have you taken any antibiotics within 4 weeks of the onset of symptoms? ❍ Y ❍ N
If so, which ones? _____

20. Have you taken any of the following within 4 weeks of the onset of symptoms?
❑ Blood Pressure Medications ❑ Aspirin ❑ Ibuprofen (Advil) ❑ Naproxen (Naprosyn, Aleve)
❑ Goody's/BC Powders ❑ Tylenol ❑ Other Pain Meds ❑ Cold/Sinus/Flu/Cough Medications ❑ Muscle Relaxants ❑ Laxatives (Metamucil) ❑ Vitamins/Supplements ❑ Herbal Meds

21. Have you had any insect bites/stings within 4 weeks of the onset of symptoms? ❍ Y ❍ N

22. Is there anything that you come in contact seem to trigger your symptoms? ❑ No ❑ Latex ❑ Pets ❑ Cosmetics
❑ Chemicals/Fumes ❑ Soaps ❑ Detergents ❑ Other: _____

23. Have you had any of the following within the last 4 weeks?
❑ Strep Throat ❑ Cold/Viral Infection ❑ Flu ❑ Skin Infection ❑ Yeast Infection ❑ Pneumonia
❑ Fungal Infection (Nails) ❑ Urinary/Bladder Infection ❑ Hepatitis ❑ Dental Infection/Abcess
❑ Diarrhea/Vomiting ❑ Other: _____

L. ENVIRONMENTAL

1. How long have you lived in Northeast Florida? _____
2. Where did you live prior to this? _____
3. In what part of town do you live? _____
4. Do you have pets in your home? ❍ Y ❍ N What kind? _____
5. Do they spend time: ❑ Indoors ❑ In Bedroom ❑ In Bed ❑ Outdoors Only
6. Do you have a gas stove, other gas appliances or gas heat? ❍ Y ❍ N

M. PAST ALLERGIC HISTORY ***(If possible, please bring allergy testing, injection schedule and records to your visit)***

1. Have you ever seen an allergist before? ❍ Y ❍ N Who? _____
Where? _____ When? _____
2. Did you have skin testing? ❍ Y ❍ N If yes, in what year? _____ Blood testing for allergies? ❍ Y ❍ N
3. Did you ever take allergy shots? ❍ Y ❍ N If so, when? _____ For how long? _____
Why did you stop? _____ Did you have any reactions to the shots? ❍ Y ❍ N
5. Have you ever seen an ENT (ears, nose, throat) specialist? ❍ Y ❍ N Who? _____
When? _____ Why? _____
6. Have you had sinus surgery? ❍ Y ❍ N When? _____
Type of surgery? _____

N. DIAGNOSTIC TESTING ***(If possible, please bring reports of X-rays and CT scans to your visit)***

1. Date of last Chest X-Ray/CT Chest? _____ Where? _____ Result? _____
2. Date of last Sinus X-Ray/CT Sinus? _____ Where? _____ Result? _____

O. DRUG ALLERGIES/ REACTIONS ***(Please use end of questionnaire if you need more room.)*** ❑ NONE

Medication	Date	Type of reaction	Medication	Date	Type of reaction
1.			**4.**		
2.			**5.**		
3.			**6.**		

P. FOOD ALLERGIES/REACTIONS ***(Please use end of questionnaire if you need more room.)*** ❑ NONE

Food	Date	Type of reaction	Food	Date	Type of reaction
1.			**4.**		
2.			**5.**		
3.			**6.**		

Q. INSECT REACTIONS ***(Please use end of questionnaire if you need more room.)*** ❑ NONE

Suspected insect	Date	Type of reaction	Suspected insect	Date	Type of reaction
1.			**4.**		
2.			**5.**		
3.			**6.**		

R. CONTACT REACTIONS (e.g. Latex, nickel, etc...) ❑ NONE

Please describe reactions. _____

T. OTHER EXISTING MEDICAL PROBLEMS

1.	**5.**	**9.**
2.	**6.**	**10.**
3.	**7.**	**11.**
4.	**8.**	**12.**

U. PREVIOUS ALLERGY/ASTHMA MEDICATIONS : Check if you have **ever** taken any of the following medications:

Antihistamines

❑ Benadryl (diphenhydramine) ❑ Atarax (hydroxyzine, Vistaril) ❑ Chlorpheniramine
❑ Claritin (loratadine/Alavert) ❑ Allegra (fexofenadine) ❑ Zyrtec (cetirizine)
❑ Xyzal (levocetirizine) ❑ Doxepin (Sinequan)

Decongestant/Antihistamines/Other

❑ Claritin-D ❑ Allegra-D ❑ Zyrtec-D ❑ Clarinex-D ❑ Singulair (montelukast)

Nasal Sprays

❑ Flonase (Fluticasone) ❑ Nasonex ❑ Nasacort (triamcinolone) ❑ Omnaris ❑ Veramyst
❑ QNasl ❑ Zetonna ❑ Astelin/Astepro (Azelastine) ❑ Patanase ❑ Afrin
❑ Ipratropium ❑ Dymista

Eye Drops

❑ Patanol/Pataday ❑ Optivar ❑ Lastacaft ❑ Elestat ❑ Zaditor ❑ Bepreve ❑ Visine

Inhalers

❑ Albuterol (Proair, Proventil, Ventolin) ❑ Xopenex ❑ Maxair ❑ Atrovent ❑ Combivent
❑ Serevent (Salmeterol) ❑ Foradil (Formoterol) ❑ Symbicort (❑ 80 / ❑ 160) Dulera (❑ 80 / ❑ 160)
❑ Advair HFA (❑ 45 / ❑ 115 / ❑ 230) ❑ Advair Diskus (❑ 100 / ❑ 250 / ❑ 500)
❑ Asmanex ❑ Qvar ❑ Pulmicort ❑ Flovent ❑ Alvesco ❑ Spiriva

Steroids/Miscellaneous

❑ Prednisone ❑ Medrol ❑ Decadron ❑ Solumedrol (Shot)
❑ Theophylline (Uniphyl, Theo-24) ❑ Singulair ❑ Xolair ❑ Epinephrine (Epi-pen)

Over The Counter Allergy Medications/Nasal Spray/Eye Drops: ❑ NONE

_____

CURRENT MEDICATIONS (include all medications that you are taking) ❑ NONE

Name and dose	Times per day	How long have you taken?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

HERBAL MEDICATIONS/SUPPLEMENTS/VITAMINS : ❑ NONE

_____

V. IMMUNIZATIONS

1. Do you receive a yearly **flu shot** ? ❍ Y ❍ N Year of last shot? _____
2. Have you ever received a **pneumonia shot**? ❍ Y ❍ N Year of last shot? _____
3. Have you had the **pertussis shot** after age 18? ❍ Y ❍ N Year of last shot? _____
4. Have you ever had the **shingles shot**? ❍ Y ❍ N Year of last shot? _____

W. FAMILY HISTORY

1. Does anyone in your immediate family have any of the following medical conditions?
   ❑ Nasal allergies ❑ Food allergies ❑ Insect allergies ❑ Drug allergies ❑ Immune deficiency
   ❑ Swelling ❑ Asthma ❑ COPD/emphysema

X. DRUG HISTORY

1. Do you smoke? ❍ Y ❍ N If so, _____ packs/day for _____ years.
2. Have you ever smoked? ❍ Y ❍ N If so, _____ packs/day for _____ years.
   In what year did you quit? _____
3. Do you live with anyone who smokes? ❍ Y ❍ N
4. Do you drink **ALCOHOL** currently? ❍ Y ❍ N If so, how much? _____
6. Do you use **ILLICIT DRUGS** or **NARCOTICS**? ❍ Y ❍ N
7. What is your occupation? _____ If none, are you: ❑ Retired ❑ Disabled

Z. REVIEW OF SYSTEMS:

GENERAL
- ❑ Excessive fatigue
- ❑ Weight loss. How much? _____
- ❑ Weight gain. How much? _____
- ❑ Fever (**within the last week**)
- ❑ Chills
- ❑ Loss of appetite
- ❑ Symptoms affect work performance
- ❑ Symptoms cause difficulty sleeping
- ❑ Symptoms limit quality of life
- ❑ Co-workers/students comment on allergy/asthma symptoms

SKIN
- ❑ Recurrent rash
- ❑ Persistent itching
- ❑ Excessive dryness

EYES
- ❑ Excessive tearing
- ❑ Cataracts/Glaucoma

HEART
- ❑ Difficulty with exertion
- ❑ Palpitations

GASTROINTESTINAL
- ❑ GERD/Acid Reflux/Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Problems swallowing

GENITOURINARY
- ❑ Difficulty urinating
- ❑ Blood/protein/sugar in urine
- ❑ Recurrent urinary infections
- ❑ Prostate problems (men)

HEME/LYMPH
- ❑ Anemia
- ❑ Blood transfusion (ever)
- ❑ Easy bleeding/bruising
- ❑ Swollen glands
- ❑ Tender glands

ENDOCRINE
- ❑ Overweight
- ❑ Thyroid problems
- ❑ Cold intolerance
- ❑ Heat intolerance

MUSCULOSKELETAL
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Osteoporosis/osteopenia
- ❑ Low Vitamin D level

NERVOUS SYSTEM
- ❑ Seizures
- ❑ Stroke or TIA
- ❑ Vertigo
- ❑ Dizziness
- ❑ Head injury
- ❑ Tremors
- ❑ Restless legs

PSYCHIATRIC
- ❑ Depression
- ❑ Frequent anxiety/tension
- ❑ Difficulty concentrating

Thank you for choosing us as your allergy and asthma specialists! *Do you have any additional information/comments to add or clarify:*