# 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:*