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

www.jaxallergy.com

2804 St. Johns Bluff Rd. S. Suite 202 Jacksonville, FL 32246 (904) 730-4870	1895 Kingsley Ave. Suite #401 Orange Park, FL 32073 (904) 272-5251	5913 Normandy Blvd. Suite #1 Jacksonville, FL 32205	**12276 San Jose Blvd., Suite 733** Jacksonville, FL 32223

PATIENT INFORMATION SHEET

DATE OF FIRST VISIT: ______________________________

MEDICATION ALLERGIES:

____

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

Sex: ❍ Male ❍ Female Date of Birth:_____-______- ________ Age: _____ SS#______-_____-_______

Marital status: ❍ Single ❍ Married ❍ Widowed ❍ Divorced E-mail: ___________________________

Home Phone: (____)_____-________ Cell: (____)______-________ Work: (____)_____-________

Home Address:

______________________________ ____________________ ________ ____________
Street/PO Box *City* *State* *Zip*

Emergency Contact Name: ___________________________________ Phone: (____)______-________

Insured Name: ___________________________ Relationship: ___________________________
(if different than above)

Insured D-O-B (*required*):______-______- ____________ Insured SS# (*required*):________-______-___________

Primary Insurance Company:___________________________ Insurance phone #: (_____)_____-________

Address on card:

______________________________ ____________________ ________ ____________
Street/PO Box *City* *State* *Zip*

Employer Name on Card: ____

Group # _________________________ Policy (ID) #: ______________________________

Secondary Insurance Company: _________________________ Insurance phone #: (_____)_____-________

Address on card:

______________________________ ____________________ ________ ____________
Street/PO Box *City* *State* *Zip*

Employer Name on Card: ____

Group #_________________________ Policy (ID) #: ______________________________

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: _______________________________

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

NEW PATIENT QUESTIONNAIRE

Date: ________________________________

Patient Name: ____ Age: ________

****** ALL PAPERWORK *MUST BE COMPLETED* PRIOR TO YOUR SCHEDULED APPOINTMENT TIME TO AVOID HAVING TO RESCHEDULE.******

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. 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: ________	❑	❑	❑

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

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 ❑ Discolored Mucus
   - ❑ Decreased Smell ❑ Decreased Taste ❑ Snoring ❑ Mouth Breathing
   - ❑ Frequent Nosebleeds ❑ Nasal Polyps
2. What makes your nasal symptoms better? ______________________________
3. When did the symptoms begin? Please be specific. ______________________________
4. Have they worsened since then? ❍ Y ❍ N
5. Are your symptoms daily? ❍ Y ❍ N

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

1. Do you have headaches? ❍ Y ❍ N If yes, how often do you get them? ❑ Monthly ❑ Weekly ❑ Daily
2. When did the symptoms begin? Please be specific. ______________________________
3. Where is the pain located?
   - ❑ Forehead ❑ Temples ❑ Mask-Like ❑ Behind Eyes ❑ Cheeks
   - ❑ Back Of Head ❑ Right Side ❑ Left Side ❑ Both Sides
4. What best describes your headache? ❑ Sinus ❑ Migraine ❑ Arthritis ❑ Tension ❑ Stress
5. Triggers? ❑ Bright Lights ❑ Loud Noises ❑ Nasal Congestion ❑ Certain Foods ❑ Stress
6. Do you have any other symptoms with the headaches?
   ❑ Nausea ❑ Vomiting ❑ Vision Changes ❑ Other: ______________________________
7. What makes your headaches better? ______________________________
8. How many sinus “infections” have you had in the past 12 months? ______________
9. Describe how you know you have a sinus infection? ❑ Worse Headache ❑ Discolored Mucus ❑ Fever
   ❑ Tiredness ❑ Fatigue ❑ “Feel Bad” ❑ Other: ______________________________
10. Were you treated with antibiotics? ❍ Y ❍ N How many times in past 12 months? ______________
    Did they help? ❍ Y ❍ N

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

1. Please check if you have any of the following symptoms:
   ❑ Burning ❑ Tearing ❑ Itching ❑ Redness ❑ Eyelid Swelling ❑ Dryness
   ❑ Other: ______________________________
2. What makes your eye symptoms better? ______________________________
3. When did the symptoms begin? Please be specific. ______________________________

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

1. Please check if you have any of the following symptoms: ❑ Fullness ❑ Popping ❑ Pain
   ❑ Plugging ❑ Decreased Hearing ❑ Dizziness/Light-Headed ❑ Ringing
2. Do you have frequent “ear infections”? ❍ Y ❍ N
   If so, how many within the past 12 months? ______________

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

1. Please check if you have any of the following symptoms: ❑ Frequent Sore Throat ❑ Throat Clearing
   ❑ Hoarseness ❑ Voice Changes ❑ Itching ❑ Burning ❑ Belching
2. Do you have frequent indigestion? ❍ Y ❍ N
   If so, how many times per week? ________________ Does it happen at night? ❍ Y ❍ N

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

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
2. When did your cough begin? ____
3. Has it worsened since then? ❍ Y ❍ N
4. Where do you feel the cough originates? ❑ Throat ❑ Middle Chest ❑ Deep Chest
5. Do you cough up mucus? ❍ Y ❍ N If so, what color is it? ______________________________
6. What seems to trigger your cough? ____
7. What makes your cough better? ____
8. Does the cough wake you up at night? ❍ Y ❍ N
9. Does the cough make you vomit? ❍ Y ❍ N

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

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? ____
   What symptoms were you having? ____
4. What makes your asthma symptoms better? ____
5. What makes your asthma symptoms worse? (see page 3 "Triggers" under Chest)
   ____
6. How have your symptoms changed since that time? ❍ Worse ❍ Better ❍ More Frequent ❍ Same
7. Describe a typical episode. ❑ Chest Tightness ❑ Wheezing ❑ Short Of Breath ❑ Coughing
8. What is your main/worst chest/breathing symptom? ______________________________________
9. Do you use a rescue inhaler (albuterol)? ❍ Y ❍ N If so, does this relieve your symptoms? ❍ Y ❍ N
10. In an **AVERAGE** week within **PAST 4 WEEKS**, how many times did you use your rescue inhaler? ____________
11. Do you wake up at night with asthma symptoms? ❍ Y ❍ N
    If so, how many times in an **AVERAGE WEEK**? ________________________
12. How many times in the past **12 months** have you been hospitalized for asthma? _____________________
    Gone to the emergency room or urgent care? _____________________
13. Have you ever been on a ventilator/breathing machine or been intubated due to your asthma? ❍ Y ❍ N
14. Do your asthma symptoms limit your activity/exercise? ❍ Y ❍ N

15. Do you feel as if your asthma is under control? ❍ Y ❍ N

16. Have you ever taken steroid pills (Medrol, prednisone, Orapred) for your asthma? ❍ Y ❍ N
    If yes, how many times in the past 12 months? ___________

17. Do you own peak flow meter? ❍ Y ❍ N If yes, do you keep track of home peak flows? ❍ Y ❍ N

18. Do you use a spacer, chamber or mask for your inhaler? ❍ Y ❍ N

19. Do you have any history of (if applicable)? ❑ Frequent Pneumonias ❑ Fibrosis ❑ Scarring Of Lungs
    ❑ COPD ❑ Emphysema ❑ Other Lung Disease: ____

20. Do you have any family history of? ❑ COPD ❑ Emphysema ❑ Fibrosis
    ❑ Other Lung Disease: ____

21.Do you have a history of sleep apnea, worn a CPAP machine or had family members observe that you "stop breathing" at night? ❍ Y ❍ N

K. <u>SKIN RASHES / ITCHING / HIVES / SWELLING / ANAPHYLAXIS</u>

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

1. 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? ____

   How was it treated? ____

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

3. What best describes your rash (<u>check all that apply</u>)?
   ❑ Raised Welts ❑ Small Bumps ❑ Large Scaly Areas ❑ Blisters ❑ Lines Of Redness
   ❑ Rough Patches ❑ Other: ____

4. 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

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

6. When did the rash/itching begin? ____
   Has it changed since then? ❍ Same ❍ Worse ❍ Better

7. How often do you have it? ❍ Daily ❍ Weekly ❍ Monthly ❍ Yearly ❍ Always ❍ Other ________

8. How long does <u>each individual lesion</u> last? ❍ 1-2 Hours ❍ 3-23 Hours ❍ 1-2 Days ❍ Longer Than 2 Days

9. Do you have itching? ❍ Y ❍ N If yes, does it keep you up at night? ❍ Y ❍ N

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

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 ❑ Other: ____________

16. Are your symptoms worse with? ❑ Stress ❑ Menstrual Periods ❑ Pregnancy
❑ Other: ______________________

17. What makes your symptoms better? ________________________________

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

19. 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: ________________________________

20. On a typical day, what do you normally eat or drink for breakfast, lunch, and dinner? Please put a * next to the foods which you had eaten within 24 hours of the onset of symptoms? Please place special emphasis on these foods that may correlate with your symptoms. Try to obtain and list the specific ingredients as well. Use end of this questionnaire if necessary.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

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

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

23. Have you had any vaccinations/immunizations within 4 weeks of the onset of symptoms? ❍ Y ❍ N

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

25. Does anything that you come in contact with trigger your symptoms? ❑ No ❑ Latex ❑ Pets ❑ Cosmetics ❑ Chemicals/Fumes ❑ Soaps ❑ Detergents ❑ Other: ______________________________

26. Have you had any IV CONTRAST DYE (for X-ray/CT scan) within 4 weeks of the reaction? ❍ Y ❍ N

27. Do you have any metal plates/pins in your bones? ❍ Y ❍ N

28. 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/Vomitting ❑ Other: ______________________________

29. What medications have you taken/were given for your symptoms?
❑ Epinephrine (Epi-pen, Twin-ject) ❑ Solumedrol (Shot) ❑ Prednisone ❑ Medrol ❑ Benadryl
❑ Albuterol Inhaler/Nebulizer ❑ Hydroxyzine (Atarax/Vistaril) ❑ Claritin (Loratadine, Alavert)
❑ Allegra (Fexofenadine) ❑ Zyrtec (Cetirizine) ❑ Clarinex ❑ Xyzal ❑ Singulair
❑ Doxepin (Sinequan) ❑ Zantac/Pepcid ❑ 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 live in a: ❍ House ❍ Apartment ❍ Mobile Home ❍ Other: ______________

5. How old is it? ______________ 6. How long have you lived there? ______________

7. Do you have any of the following TREES in your neighborhood?
❑ Oak ❑ Maple ❑ Pine ❑ Bayberry ❑ Ligustrum ❑ Pecan ❑ Other: ______________

8. Is your comforter: ❍ Feather ❍ Non-Feather 9. Do you have any feather pillows? ❍ Y ❍ N

10. Do you have allergy covers for any of the following? ❑ Pillows ❑ Mattress ❑ Boxspring

11. Do you have any stuffed animals? ❍ Y ❍ N If so, are they: ❑ In Bedroom ❑ In Bed ❑ Neither

12. Do you have carpet in any of the following? ❑ Bedroom ❑ Living Room/Den ❑ Other ❑ None

13. How often is your home cleaned? ____________ Dusted? ____________ Vacuumed? ____________

14. How dusty do you think your home is? ❍ No Dust ❍ Minimal ❍ Average ❍ Above Average

15. Do you have any mold/mildew/musty smells in your home? ❍ Y ❍ N If so, where? ______________

16. What kind of heating and air-conditioner do you have? ❑ Central ❑ Window ❑ None

17. Are your windows closed year round? ❍ Y ❍ N

18. Do you have a HEPA air filter for: ❑ Bedroom ❑ Living Room ❑ Central ❑ Vacuum

19. Do you have pets in your home? ❍ Y ❍ N What kind? ______________________________

How long have you had them? ______________________________

20. Do they spend time: ❑ Indoors ❑ In Bedroom ❑ In Bed ❑ Outdoors Only

21. 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

4. Were you ever treated for any of the following?

   ❑ Nasal Allergies ❑ Asthma ❑ Pneumonia ❑ Bronchitis ❑ Sinusitis ❑ Nasal Polyps

   ❑ Eczema ❑ Hives ❑ Swelling ❑ Immune Deficiency ❑ Ear Infections ❑ Croup/RSV

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? ____________________

7. What was your birth weight? ________ pounds ________ ounces Were there any birth complications? ❍ Y ❍ N

8. Did you have any "allergic problems" as an infant? ❍ Y ❍ N If yes, please specify: ____________________

9. Were you breastfed (children only)? ❍ Y ❍ N If so, for how long? ____________________

10. Did you have feeding difficulties as an infant? ❍ Y ❍ N Colic? ❍ Y ❍ N Food allergies? ❍ Y ❍ N

11. Did you have any serious illness as a child? ❍ Y ❍ N If yes, please specify: ____________________

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? ____________

3. Last PPD (Tuberculosis test)? ____________ Where? ____________ Result? ____________

O. DRUG 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 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) ❑ NONE

Please describe reactions. ____________________

S. ASPIRIN INTOLERANCE ❑ NONE

Please describe reactions. ____________________

T. HOSPITALIZATIONS, SURGERIES, OTHER MEDICAL PROBLEMS

1. Hospitalizations/ER Visits

Reason for ER visit/Hospitalization	Date	Reason for ER visit/Hospitalization	Date
1.		4.	
2.		5.	
3.		6.	

2. Surgical History

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

3. Other Medical Problems

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

U. MEDICATIONS (**** PLEASE USE END OF QUESTIONNAIRE IF YOU NEED MORE ROOM ****)

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)
❑ Clarinex ❑ Xyzal

Decongestant/Antihistamines/Other

❑ Claritin-D ❑ Allegra-D ❑ Zyrtec-D ❑ Clarinex-D ❑ Aller-X ❑ Singulair

Nasal Sprays

❑ Flonase (Fluticasone) ❑ Nasonex ❑ Nasacort ❑ Rhinocort ❑ Nasarel ❑ Astelin
❑ Astepro ❑ Veramyst ❑ Omnaris ❑ Patanase ❑ Afrin ❑ Ipratropium

Eye Drops

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

Inhalers

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

Steroids/Miscellaneous

❑ Prednisone ❑ Medrol ❑ Decadron ❑ Solumedrol (Shot)
❑ Theophylline (Uniphyl, Theo-24) ❑ Singulair

Epinephrine

❑ Epi-Pen ❑ Twin-Ject ❑ Adrenaclick

Other Prescription Medications/Inhalers:

Over The Counter Pill Medications:

Over The Counter Nasal Sprays Or Eye Drops:

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

Name	Times per day	How long have you taken?
1.		
2.		
3.		
4.		
5.		

ANTIBIOTICS (please list names of all that you have taken in last 12 months) ❑ NONE

Name and dose	Times per day	How long did you take?	Did it help?
1.			❍ Y ❍ N
2.			❍ Y ❍ N
3.			❍ Y ❍ N
4.			❍ Y ❍ N
5.			❍ Y ❍ N
6.			❍ Y ❍ N
7.			❍ Y ❍ N

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. Are the remainder of your shots up to date? ❍ Y ❍ N

W. FAMILY HISTORY

1. Does anyone in your immediate family have asthma, COPD, emphysema, eczema, nasal allergies, food allergies, medication allergies, hives, swelling, or immune deficiency ? ❍ Y ❍ N If yes, please specify.

2. Immediate Family History (If deceased, please place a D in appropriate box under "age" column)

	AGE	HEALTH CONDITIONS		AGE	HEALTH CONDITIONS
Mother			**Father**		
Sister(s)			**Daughter(s)**		
Brother(s)			**Son(s)**		

3. Do any other chronic diseases run in your family (heart, lungs, kidney, diabetes, cancer, stroke, etc.)? ❍ Y ❍ N
If yes, please specify. ____

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? ______________________________
5. Have you ever abused **ALCOHOL**? ❍ Y ❍ N
6. Do you use **ILLICIT DRUGS** or **NARCOTICS**? ❍ Y ❍ N
7. Have you ever abused **ILLICIT DRUGS** or **NARCOTICS**? ❍ Y ❍ N
8. **Do you have any risk factors that may affect your health? ❍ Y ❍ N**

   If yes, please specify. ____

Y. SOCIAL HISTORY

1. What is your occupation? ______________________________ If none, are you: ❑ Retired ❑ Disabled
2. Are you exposed to any chemicals/fumes either at home or at work? ❍ Y ❍ N
3. What are your hobbies? ____
4. Do you live alone? ❍ Y ❍ N
5. Do you have a spouse? ❍ Y ❍ N ❍ Deceased If yes, how old? _____________
6. Do you care for anyone in your home (spouse, children, other) with a chronic illness? ❍ Y ❍ N

   If yes, please specify. ____
7. Please select current/highest educational level:
   ❍Pre-K** ❍K ❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10 ❍11 ❍12 ❍College ❍Post-College

   ** If your child attends pre-K, how many days per week? __________ How many children in class? ______________
8. How much work /school have you/your child missed over the past 12 months because of your allergies/ asthma? __________
9. How many days of work have you missed due to your illnesses over the last 12 months? ________________________

Z. REVIEW OF SYSTEMS: Check if you have had any of the following **WITHIN THE LAST 12 MONTHS**

GENERAL
- ❑ Excessive fatigue
- ❑ Weight loss. How much? _________
- ❑ Weight gain. How much? _________
- ❑ Fever (**within the last week**)
- ❑ Chills
- ❑ Loss of appetite
- ❑ Stop breathing at night (sleep apnea)
- ❑ Symptoms affect work performance
- ❑ Symptoms cause difficulty sleeping
- ❑ Symptoms limit quality of life
- ❑ Co-workers/students comment on allergy/asthma symptoms
- ❑ Difficulty concentrating
- ❑ Date of last physical exam: __________
- ❑ Date of most recent lab work: __________
- ❑ HIV testing

SKIN
- ❑ Recurrent rash
- ❑ Persistent itching
- ❑ Excessive dryness
- ❑ Easy bruising
- ❑ Moles that have changed color/size
- ❑ Hair loss

EYES
- ❑ Double vision
- ❑ Blurry vision
- ❑ Cataracts/Glaucoma
- ❑ Blindness

HEART
- ❑ Murmur
- ❑ Difficulty with exertion
- ❑ Palpitations
- ❑ Chest pain
- ❑ Heart attack
- ❑ Congestive Heart Failure
- ❑ Cardiac arrhythmia

GASTROINTESTINAL
- ❑ GERD/Acid Reflux/Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Ulcers
- ❑ Bloody/black stool
- ❑ Change in bowel movements
- ❑ Liver Disease/Hepatitis
- ❑ Gallbladder Disease
- ❑ Problems swallowing
- ❑ Significant dental problems

GENITOURINARY
- ❑ Difficulty urinating
- ❑ Blood/protein/sugar in urine
- ❑ Recurrent urinary infections
- ❑ Frequent nighttime urination
- ❑ Prostate problems (men)
- ❑ Kidney stone
- ❑ STD/venereal disease

MUSCULOSKELETAL
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Frequent back pain
- ❑ Fracture/broken bones
- ❑ Osteoporosis/osteopenia/ weak bones

NERVOUS SYSTEM
- ❑ Seizures
- ❑ Stroke or TIA
- ❑ Loss of consciousness
- ❑ Vertigo
- ❑ Dizziness
- ❑ Loss of feeling
- ❑ Head injury
- ❑ Tremors
- ❑ Restless legs

PSYCHIATRIC
- ❑ Depression
- ❑ Frequent anxiety/tension
- ❑ Other personal problems that cause great concern
- ❑ See a psychiatrist/neurologist

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

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

Do you have any additional information/comments to add/clarify that are not covered in the above questionnaire?
❍ Y ❍ N

If yes, please use the space below.