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**	❑	❑	❑				

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) ❑ Clarinex ❑ 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
4. Have you ever seen an ENT (ears, nose, throat) specialist? ❍ Y ❍ N Who? _____
When? _____ Why? _____
5. 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. _____

S. OTHER EXISTING MEDICAL PROBLEMS

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

T. 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 ❑ 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
❑ Breo (❑ 100 / ❑ 200) ❑ Trelegy

Steroids/Miscellaneous

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

U. 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.		

V. HERBAL MEDICATIONS/SUPPLEMENTS/VITAMINS: ❑ NONE

_____

_____

_____

W. 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. 4. Have you ever had the **shingles shot**? ❍ Y ❍ N Year of last shot? _____

X. 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

Y. 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.
3. In what year did you quit?_____
4. Do you live with anyone who smokes? ❍ Y ❍ N
5. Do you drink **ALCOHOL** currently? ❍ Y ❍ N If so, how much?_____
6. 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:*

_____

_____

_____