NEW PATIENT QUESTIONNAIRE

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*

Email address: _____

Emergency Contact Name: _____ **Phone:** (_____)_____-_____
Relationship

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

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

Primary Care Provider: _____ **Phone:** (_____)_____-_____

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

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

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

Mail Order Pharmacy: _____ **Phone:** (_____)_____-_____

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

How did you hear about us?

❍ Referring provider ❍ Another patient/friend ❍ Insurance directory/website ❍ Social Media/ Facebook

❍Internet search (Google, Yahoo) ❍ www.JaxAllergy.com ❍ Advertisement ❍ Other:_____

A. What is the **ONE** main problem (chief complaint) which caused you to visit us?

_____

B. If time permits, what other "allergic" problems may we address at your visit?

_____

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, please check the box and 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 ❑ Itching ❑ 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 Change ❑ 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. On average, **how many times PER WEEK** did you use your rescue inhaler within the **PAST 4 WEEKS**? _____
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) or steroid shots for your asthma? ❍ Y ❍ N

    If yes, how many total 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/ 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, 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. Which medications have you taken/were given for your symptoms?
   ❑ Epinephrine (Epi-pen, Auvi-Q) ❑ Steroid shot (Solumedrol, Decadron, Depo-medrol, Kenalog) ❑ Prednisone
   ❑ Medrol ❑ Benadryl ❑ Albuterol ❑ Hydroxyzine (Atarax/Vistaril) ❑ Zyrtec (cetirizine)
   ❑ Claritin (loratadine, Alavert) ❑ Allegra (fexofenadine) ❑ Xyzal (levocetirizine) ❑ Clarinex (desloratadine)
   ❑ Singulair (montelukast) ❑ Doxepin (Sinequan) ❑ Zantac (ranitidine)/Pepcid (famotidine)
   ❑ Other: _____
4. Which best describes your rash (check all that apply)?
   ❑ Raised Welts ❑ Small Bumps ❑ Scaly Areas ❑ Blisters ❑ Lines of Redness ❑ Red Blotches
   ❑ Rough Patches ❑ Other: _____
5. What is the size of 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? (approximately date) _____
   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? ❍ Less than 60 min ❍ 1-23 Hours ❍ 1-2 Days ❍ More 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/when 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, etc.) ❑ 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/Abscess
❑ 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? _____
   Do they spend time: ❑ Indoors ❑ In Bedroom ❑ In Bed ❑ Outdoors Only
5. Do you have a gas stove? ❍ Y ❍ N

M. PAST ALLERGIC HISTORY *(If possible, please bring allergy testing, injection schedule and related 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/surgeon? ❍ 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 Tablets

❑ 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) ❑ Flonase Sensimist ❑ Nasacort (triamcinolone) ❑ Veramyst ❑ Omnaris
❑ QNasl ❑ Zetonna ❑ Xhance ❑ Dymista ❑ Ipratropium
❑ Astelin/Astepro (Azelastine) ❑ Patanase (olapatadine) ❑ Nasonex (mometasone)
❑ Afrin/Vicks/Sinex/Oxymetazoline/Phenylephrine

Eye Drops

❑Olapatadine (Pazeo, Pataday, Patanol) ❑ Azelastine (Optivar) ❑ Alcaftadine (Lastacaft)

❑ Epinastine (Elestat) ❑ Ketotifen (Alaway, Zaditor) ❑ Visine, Naphcon-A, Clear Eyes, Opcon-A, naphazoline, tetrahydrozoline

Inhalers

❑ Albuterol (Proair, Proventil, Ventolin) ❑ Xopenex (levalbuterol) ❑ Maxair ❑ Atrovent ❑ Combivent

❑ Serevent (Salmeterol) ❑ Foradil (Formoterol) ❑ Symbicort O 80 / O 160 ❑ Dulera O 100 / O 200

❑ Advair HFA (Fluticasone/Salmeterol) O 45 / O 115 / O 230 ❑ Advair Diskus O 100 / O 250 / O 500

❑ Wixela O 100 / O 250 / O 500 ❑ Asmanex ❑ Qvar O 40 / O 80 ❑ Pulmicort O 90 / O 180

❑ Flovent O 44 / O 110 / O 220 ❑ Alvesco (ciclesonide) O 80 / O 160 ❑ Spiriva O 1.25 / O 2.5

Steroids/Injectables/ Miscellaneous

❑ Prednisone ❑ Medrol ❑ Decadron ❑ Solumedrol (Shot) ❑ Singulair (montelukast)

❑ Xolair ❑ Dupixent ❑ Nucala ❑ Fasenra ❑ Epinephrine (Epi-pen, AuviQ)

❑ Theophylline (Uniphyl, Theo-24)

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 the "**Pneumovax**" **pneumonia shot**? ❍ Y ❍ N Year of last shot? _____
3. Have you ever received the "**Prevnar**" **pneumonia shot**? ❍ Y ❍ N Year of last shot? _____
4. Have you had the **pertussis shot** after age 18? ❍ Y ❍ N Year of last shot? _____
5. 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
   - ❑ Swelling ❑ Asthma ❑ COPD/emphysema ❑ Immune deficiency

Y. DRUG HISTORY

1. Do you smoke? ❍ Y ❍ N If so, _____ packs/day for _____ years ❑ Vaping ❑ Marijuana
2. Have you ever smoked? ❍ Y ❍ N If so, _____ packs/day for _____ years ❑ Vaping ❑ Marijuana
   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. Do you use **ILLICIT DRUGS** or **NARCOTICS**? ❍ Y ❍ N
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?*

_____

_____