NEW PATIENT QUESTIONNAIRE

Date of first visit: _____ - _____ - _____

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

Date of Birth: _____-_____-_____ **Age**: _____ **Sex Assigned at Birth**: ❍ 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 *City* *State* *Zip*

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

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

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

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

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

Address: _____ _____ _____ _____
Street *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	❑ Nasal Polyps	❑ Facial pressure/ Headaches	

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

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

2. Have you ever seen an ENT (ears, nose, throat) specialist/surgeon? ❍ Y ❍ N Who?_____
   When? _____ Why? _____

3. Have you had sinus surgery? ❍ Y ❍ N When:_____
   Type of surgery: _____

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 ❑ 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

2. Is your cough associated with trouble breathing or wheezing (high pitched whistle)? ❑ Yes ❑ No

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. How many times in the **past 12 months** have you taken steroid pills (Medrol, prednisone, Orapred) or steroid shots for your asthma _____.
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*
Spring	❑	❑	❑	**Work**	❑	❑	❑
Summer	❑	❑	❑	**Home**	❑	❑	❑
Fall	❑	❑	❑	**Odors**	❑	❑	❑
Winter	❑	❑	❑	**Smoke**	❑	❑	❑
Season change	❑	❑	❑	**House dust**	❑	❑	❑
All year	❑	❑	❑	**Mold/ Mildew**	❑	❑	❑
Indoors	❑	❑	❑	**Pollen**	❑	❑	❑
Outdoors	❑	❑	❑	**Cats**	❑	❑	❑
Daytime	❑	❑	❑	**Dogs**	❑	❑	❑
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. What do you think caused/triggered your symptoms? _____
3. Have you seen another physician for your symptoms? ❍ No ❍ PCP ❍ Allergist ❍Dermatologist ❍ ER ❍ Urgent Care
   Name of physician(s):_____ Date(s) seen:_____
   What diagnosis was made? _____
4. 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) ❑ Pepcid/Zantac (famotidine)
   ❑ Topical steroids ❑ Protopic (tacrolimus) ❑ Elidel (pimecrolimus) ❑ Eucrisa ❑ Dupixent ❑ Xolair
   ❑ Other: _____
5. Which best describes your rash (check all that apply)?
   ❑ Raised Welts ❑ Small Bumps ❑ Scaly Areas ❑ Blisters ❑ Lines of Redness ❑ Red Blotches
   ❑ Rough Patches ❑ Other: _____
6. What is the typical size of each individual spot?
   ❑ VARYING sizes ❑ SMALLER than a pea ❑ PEA size ❑ NICKEL size ❑ QUARTER size
   ❑ LARGER than half dollar ❑ HALF DOLLAR size
7. Where was/is the rash located (check all that apply)?
   ❑ Entire Body ❑ Scalp ❑ Face ❑ Around eyes ❑ Neck ❑ Chest ❑ Back ❑ Abdomen ❑ Waistline
   ❑ Arms ❑ Hands ❑ Groin ❑ Buttock ❑ Legs ❑ Feet
8. **When** (approximate date) did the rash/reaction begin? _____
   Has it changed since then? ❍ Same ❍ Worse ❍ Better ❍ Resolved completely
9. How often do you have it? ❍ Always ❍ Daily ❍ Weekly ❍ Monthly ❍ Yearly ❍ Other _____
10. **How long does each spot last on the skin**? ❍ Less than 60 min ❍ 1-23 Hours ❍ 1-2 Days ❍ More than 2 Days
11. Does the rash do any of the following? ❑ Itch ❑ Burn ❑ Sting ❑ Hurt ❑ Leave A Bruise
12. Do you have any swelling? ❍ Y ❍ N If yes, where? ❑ Lips ❑ Tongue ❑ Eyes ❑ Hands ❑ Feet
13. Do any of the following trigger the hives/swelling/rash?
    ❑ Heat ❑ Showering/Bathing ❑ Exercise ❑ Sunlight ❑ Pressure/Prolonged Sitting ❑ Vibration
    ❑ Friction/Tight Clothes ❑ Rubbing/Scratching ❑ Cold Temperatures ❑ Stress/Anxiety
14. What makes your symptoms better? _____
15. Have you taken any antibiotics within 4 weeks of the onset of symptoms? ❍ Y ❍ N
    If so, which ones? _____
16. Have you taken any of the following within 4 weeks of the onset of symptoms?
    ❑ Aspirin ❑ Ibuprofen (Advil) ❑ Naproxen (Naprosyn, Aleve) ❑ Goody's/BC Powders ❑ Other Pain Meds
    ❑ Cold/Sinus/Flu/Cough Medications ❑ Vitamins/Supplements ❑ Herbal Meds ❑ Blood Pressure Meds

17. Is there anything that you come in contact seem to trigger your rash symptoms? ❑ No ❑ Latex ❑ Pets
❑ Cosmetics ❑ Chemicals/Fumes ❑ Perfume/Cologne ❑ Soaps ❑ Detergents ❑ Plants ❑ Other:

18. Have you had any of the following **infections** within the 4 weeks prior to rash/swelling onset?
❑ Strep Throat ❑ Viral Respiratory Infections (colds/flu) ❑ Skin Infection ❑ Yeast Infection ❑ Pneumonia
❑ Urinary/Bladder Infection ❑ Dental Infection/Abscess ❑ Diarrhea/Vomiting ❑ Other: _____

L. OTHER EXISTING MEDICAL PROBLEMS ❑ NONE

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

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 bad reactions to the shots? ❍ Y ❍ N

N. DRUG ALLERGIES/ REACTIONS ❑ NONE

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

O. FOOD ALLERGIES/REACTIONS ❑ NONE

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

P. INSECT REACTIONS ❑ NONE

Insect	Date	Type of reaction	Suspected Insect	Date	Type of reaction
1.			**3.**		
2.			**4.**		

Q. SKIN CONTACT REACTIONS (e.g. Latex, nickel, cosmetics, adhesives etc...) ❑ NONE

Please describe trigger/reaction: _____

R. ENVIRONMENTAL/SOCIAL HISTORY

1. What is your occupation? _____ ❑ Retired ❑ Disabled ❑ Student
2. How long have you lived in Northeast Florida? _____
3. Where did you live prior to this? _____
4. Do you have pets in your home? ❍ Y ❍ N What kind? _____

   Where are the pets? ❑Outdoors and indoors ❑ In house, not in bedroom ❑ In bedroom, not in bed ❑ In bed
5. Do you currently smoke? ❍ Y ❍ N If so, _____ packs/day for _____ years ❑ Vaping ❑ Marijuana
6. Have you ever smoked? ❍ Y ❍ N If so, _____ packs/day for _____ years ❑ Vaping ❑ Marijuana

   In what year did you quit? _____
7. Do you live with anyone who smokes? ❍ Y ❍ N

S. 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 Tablets/ Antihistamines/ Other

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

Nasal Sprays

❑ Flonase (Fluticasone) ❑ Flonase Sensimist ❑ Nasacort (triamcinolone) ❑ Rhinocort (budesonide)
❑ QNasl ❑ Ryaltris ❑ Xhance ❑ Dymista ❑ Ipratropium
❑ Astelin/Astepro (azelastine) ❑ Patanase (olapatadine) ❑ Nasonex (mometasone)
❑ Afrin/Vicks/Sinex/Oxymetazoline/Phenylephrine ❑ Other nasal spray: _____

Eye Drops

❑ Olapatadine (Pataday, Pazeo, Patanol) ❑ Azelastine (Optivar) ❑ Alcaftadine (Lastacaft)
❑ Zerviate (cetirizine) ❑ Epinastine (Elestat) ❑ Ketotifen (Alaway, Zaditor)
❑ Visine, Naphcon-A, Clear Eyes, Opcon-A, naphazoline, tetrahydrozoline

Inhalers

❑ Albuterol (ProAir, Proventil, Ventolin) ❑ Levalbuterol (Xopenex) ❑ Atrovent/Ipratropium ❑ Combivent
❑ Advair (Fluticasone/ Salmeterol) ❑ Wixela (Fluticasone/ Salmeterol) ❑ Asmanex ❑ Dulera
❑ Symbicort (Budesonide/Formoterol) ❑ Breo (Fluticasone/ Vilanterol) ❑ Pulmicort (Budesonide) ❑ Qvar
❑ Spiriva (Tiotropium) ❑ Flovent ❑ Alvesco ❑ Arnuity
❑ Trelegy

Steroids/Biologics/ Miscellaneous

❑ Prednisone ❑ Medrol ❑ Decadron ❑ Solumedrol (Shot) ❑ Singulair (montelukast)
❑ Xolair ❑ Dupixent ❑ Nucala ❑ Fasenra ❑ Tezspire
❑ Epinephrine injector (EpiPen, Auvi-Q)

T. CURRENT MEDICATIONS (include all medications/vitamins/supplements that you are taking now) ❑ NONE

Name and Dose	Times per day	How long have you been taking it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

U. FAMILY HISTORY

1. Does anyone in your immediate family (*your mother, father, siblings only*) have any of the following medical conditions?

❑ Swelling ❑ Asthma ❑ COPD/emphysema ❑ Immune deficiency

V. HEALTH MAINTENANCE/ 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? _____

W. 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? _____

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

_____

PJD-TAL 7/2023