TALLAHASSEE
ALLERGY, ASTHMA & IMMUNOLOGY
SPECIALIZING IN ADULT AND PEDIATRIC ALLERGIC DISORDERS

BRIAN G. WILSON, M.D.
NARLITO V. CRUZ, M.D.

NEW PATIENT PACKET

Thank you for choosing Tallahassee Allergy, Asthma & Immunology. Per your request, we have reserved an appointment just for you with **Dr. Brian Wilson**. You'll need to arrive 15 minutes before your scheduled time (patient's arriving late may be rescheduled) and allow approximately **2 hours** for this initial appointment. ***Please visit the patient portal link in this email to complete your Medical History Questionnaires. In addition, please be sure to bring this attached form (1) completed, any insurance cards, a government issued photo ID and a list of all medications you take (both prescriptions and over the counter, including doses) with you.*** Any referrals or records needed for your visit should be faxed to (850) 656-7729. Please note that you should avoid taking any antihistamines prior to the appointment if at all possible. Below are examples of medications to stop taking.

Two weeks prior to skin test: **Doxepin** (Sinequan)

One week prior to skin test:

Antihistamine/Allergy Pills: **Allegra** (fexofenidene), **Zyrtec** (cetirizine), **Benadryl** (diphenhydramine), **Claritin/Clarinex** (loratidine/desloratidine), **Xyzal** (levocetirizine dihydrochloride), **Atarax/Vistaril** (hydroxyzine), **Deconamine** (chlorpheniramine pseudoephed), **Allerhist/Antihist/Contac/Dayhist/Tavist** (clemastine, meclastine fumarate, mecloprodin fumarate)

Nasal Sprays: **Astelin**, **Patanase, Dymista**

Eye Drops: **Patanol**, **Pataday**, **Zaditor**, **Optivar**, **Elestat**

Sleep Aid Medicines: **Tylenol PM**, **Advil PM**, **Excedrin PM**, **Midol PM, Unisom**. doxylamine succinate

Over The Counter Heartburn Medicines: **Zantac** (Ranitidine), **Pepcid** (Famotidine), **Axid** (Nizatidine)

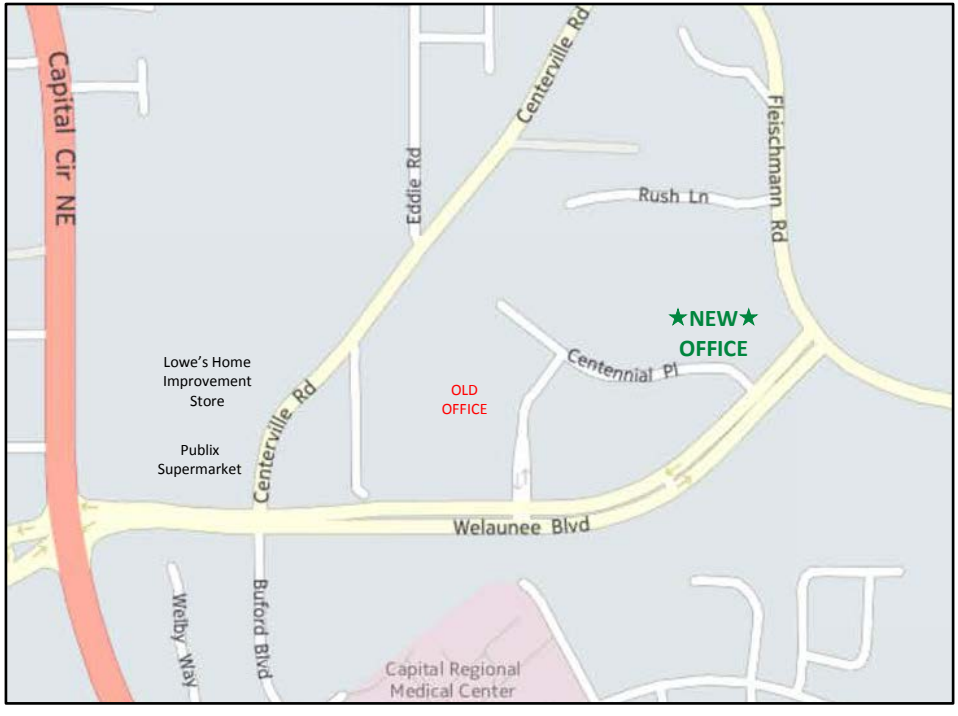
Various Over The Counter "Cold & Allergy" Medicines (including but not limited to): **Tavist**

Misc.: **Phenergan** (promethazine)

Please be advised that there is $75 CANCELLATION/NO SHOW FEE for any appointments missed, cancelled or rescheduled with less than 24 hours notice. ***Also please note if minors (anyone under 18) are not accompanied to the visit by a legal parent/guardian capable of giving a complete detailed medical history the appointment WILL be rescheduled.*** If you have any questions, please feel free to call our office. Thank you.

Tallahassee Allergy, Asthma & Immunology

Brian G. Wilson, MD Narlito V. Cruz, MD



Call for further directions: (850) 656-7720

OUR NEW OFFICE IS LOCATED AT:

2646 Centennial Place Suite B

- *From Capital Circle:* Go East on Centerville Road
- Continue straight through light onto Welaunee Blvd
- Take 1st left after the light onto Centennial Blvd
- Turn right onto Centennial Place
- Our office is located on the left just past The Growing Room before you get to Welaunee Blvd

- *From Fleischmann Road:* Go West on Welaunee Blvd towards Capital Circle
- Take 1st right onto Centennial Place
- Our office will be on the right

Tallahassee Allergy, Asthma & Immunology - PATIENT INFORMATION FORM

Date | Insurance Company Name(s) | Insurance ID/Policy/Subscriber Number(s)

Patient Last Name | Middle Initial | Primary Care Physician & Phone Number

Patient First Name | Gender | Referring Physician & Phone Number

Previous Name | DOB | Race/Ethnicity | Marital Status | SSN

Patient Home Address | Patient Employer/School Name | Status: ☐ Full-time ☐ Part-time

City | Employer Address

State | Zip | City | State | Zip

Patient Home Phone ☐ **OK to leave messages** | Patient Cell Phone ☐ **OK to leave messages** | Patient Work Phone ☐ **OK to leave messages**

Pharmacy Name & Location ☐ **OK to verify Rx History Electronically** | Email Address (if patient is a minor, list a parent's, only one email address is necessary)

Additional Contact Info-Spouse, Mother (if Minor) or Emergency Contact:

First & Last Name:

If Spouse or Mother of Minor or Insurance Policy Holder Complete This ENTIRE Section. If Emergency Contact Only Complete ONLY Name & Phone Numbers.

Relationship to Patient | ☐ **Check if Address is same as Patient-IF NOT:** | Address | City | State | Zip

Home Phone ☐ **OK to leave messages** | Cell Phone ☐ **OK to leave messages** | Work Phone ☐ **OK to leave messages**

DOB | SSN | Employer

☐ **Check if this person is the insurance policy holder**

☐ **Check if this person is permitted to receive information on the patient** | Employer Address | City | State | Zip

Additional Contact Info-Father (if Minor) or Emergency Contact:

First & Last Name:

If Father of Minor or Insurance Policy Holder Complete This ENTIRE Section. If Emergency Contact Only Complete ONLY Name & Phone Numbers.

Relationship to Patient | ☐ **Check if Address is same as Patient-IF NOT:** | Address | City | State | Zip

Home Phone ☐ **OK to leave messages** | Cell Phone ☐ **OK to leave messages** | Work Phone ☐ **OK to leave messages**

DOB | SSN | Employer

☐ **Check if this person is the insurance policy holder**

☐ **Check if this person is permitted to receive information on the patient** | Employer Address | City | State | Zip

PLEASE NOTE THAT QUOTE OF BENEFITS & ELIGIBILITY FROM YOUR INSURANCE COMPANY DOES NOT GUARANTEE COVERAGE OR PAYMENT. DEDUCTIBLES & CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. THEREFORE, IT IS THE POLICY OF THIS PRACTICE TO COLLECT THESE PAYMENTS AT THE TIME OF SERVICE. I am aware of the $75 fee for any appointments missed, cancelled or rescheduled with less than 24 hours notice. I understand that I am financially responsible for any balance. I authorize my insurance benefits be paid directly to TAAI. I authorize the release of any medical information: required to process my claims; to be left on messages at the numbers checked off above; to the contacts checked off above; and to my primary care physician & referring physician. I acknowledge that I have been offered a copy TAAI's Notice of Privacy Practices, (also posted in the lobby). The above information is true to the best of my knowledge.

✸ Patient Signature (If patient is a minor, then guarantor/parent signature) | Relationship to Patient | Date

TALLAHASSEE ALLERGY, ASTHMA & IMMUNOLOGY
PATIENT REVIEW OF SYSTEMS FORM

Please take a few moments to complete the following form. If you are a parent or guardian, answer the questions as best you can for the patient to be seen. The information gathered below will assist us in better evaluating you or your family member. You will have the opportunity to discuss this information further with the doctor during your appointment. If you have any questions regarding this form, please ask the receptionist. **PLEASE COMPLETE IN BLACK OR BLUE INK ONLY AND DO NOT ADD ANY EXTRA INFORMATION TO THIS PAGE.**

ALLERGY

Eye symptoms? O none O red O itch O watery O dry O eyelid irritation/rash O discharge O change in vision

Nasal symptoms? O none O sneezing O itch O runny O congested O stuffy O post nasal drip O bleeding

Sinus symptoms? O none O pain O pressure O headaches O fullness O infections

Ear symptoms? O none O fullness O recurrent ear infection O history of ear tube(s)

Chest/breathing problems? O none O asthma O wheezing O recurrent pneumonia O chronic cough

Allergy problems? O none O eczema/atopic dermatitis O food allergy O insect allergy O hives/urticaria

O anaphylaxis

ENVIRONMENTAL HISTORY

Where do you currently live? O house O apartment O mobile home O dorm

Do you have any of the following pets? O none O cat O dog O bird O hamster/gerbil O other

Do you smoke or are you exposed to smoke? O none O at home O at work O at home & work

Do you use dust mite covers? O Yes O No O on pillows O on mattress O on box spring

Are you exposed or have you been exposed to mold? O Yes O No O Unsure

IMMUNE SYSTEM

Is the patient up to date on all childhood immunizations? O Yes O No O Unsure

Is there a known family history of immune deficiency? O Yes O No O Unsure

Is there a family history of unusual infections or childhood deaths? O Yes O No O Unsure

Has the patient had previous pneumonia vaccination? O Yes O No O Unsure

CONSTITUTIONAL SYMPTOMS

O none O weight loss O weight gain O loss of appetite O fever O weakness O fatigue

ENT SYMPTOMS

O none O cold O cough O nose bleeds O hearing loss O voice change O sore throat O ringing in ears

O sinus pain O nasal polyps O sinus surgery

RESPIRATORY SYMPTOMS

O none O bronchitis O emphysema O recurrent pneumonia O shortness of breath O chest pain O chest condition

O cough

PATIENT REVIEW OF SYSTEMS FORM – PAGE 2

CARDIOVASCULAR

O none O heart attack O high blood pressure O dizziness O chest pain O palpitations O leg edema
O varicose veins

OPTHALMOLOGY

O none O vision loss O diminished vision O blurring of vision O eye irritation O eye drainage
O seasonal eye symptoms O puffy lids

ENDOCRINOLOGY

O none O frequent thirst/polydipsia O frequent urination/polyuria O sleep disturbance O cold intolerance
O heat intolerance

GASTROENTEROLOGY

O none O nausea O vomiting O heartburn O trouble swallowing/dysphagia O abdominal pain O hemorrhoids
O diarrhea O constipation O blood in stool

UROLOGY

O none O recurrent UTI O difficulty urinating O frequent urination O urinary incontinence O blood in urine

DERMATOLOGY

O none O itch O rash O dry or sensitive skin O hives O mole O lumps O skin cancer

NEUROLOGY

O none O headache O weakness O tingling or numbness O seizures O insomnia O memory loss O dizziness
O gait abnormality

HEMATOLOGY/LYMPH

O none O swollen glands O fatigue O loss of appetite O varicose veins O easy bruising

MUSCULOSKELETAL

O none O joint stiffness O joint pain O joint swelling O leg cramps O sciatica

PSYCHOLOGY

O none O depression O anxiety O high stress level O sleep disturbances O suicidal ideation O eating disorder
O mental or physical abuse

MALE REPRODUCTIVE

O none O difficulty with erection O diminished sexual drive O penile discharge

FEMALE REPRODUCTIVE

O none O frequent yeast infections O abnormal vaginal discharge O heavy or painful periods O painful intercourse
O infertility O hot flashes

PATIENT REVIEW OF SYSTEMS FORM – PAGE 3

SOCIAL HISTORY

Do you currently smoke? O Yes O No

Have you smoked in the past? O Yes O No

Do you drink alcohol? O Yes O No

Do you use recreational drugs? O Yes O No

How often do you exercise? O daily O 3-4 days/week O occasionally O never

Do you consume caffeine? O Yes O No

Have you traveled outside the US? O Yes O No

Are you currently sexually active? O Yes O No

Have you been exposed to any of the following while at work? O none O animals O asbestos O cleaning fluids O grain dust O industrial chemicals O strong odors O other