

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. At your request, we have reserved an appointment just for you with Dr. Brian Wilson or Dr. Narlito Cruz. Please review the information below to prepare for your appointment.

*If your appointment is only for a **venom allergy, hives (urticaria), immune deficiency or HAE**, please DO NOT STOP taking any of your medications.

*If you are scheduled for **patch testing for contact dermatitis**, four (4) weeks prior to your appointment, you will need to STOP TAKING ALL oral or injectable steroids (such as prednisone or kenalog shots) and STOP USING ANY steroid cream on your back only (you may use steroid cream on other parts of your body as directed).

*If you are scheduled for **allergy symptoms, rhinitis, sinusitis or asthma** you will need to STOP TAKING THE FOLLOWING MEDICATIONS to allow for **skin prick testing for environmental allergies (animals, pollens, molds, etc) or food allergies**, only stop the medications listed DO NOT STOP ASTHMA MEDICATIONS. Failure to stop medication as requested will result in the need to schedule you at our next available appointment to complete your testing and assessment.

Two (2) weeks prior to skin test STOP: **Doxepin** (Sinequan)

One (1) week prior to skin test STOP:

****ANY and ALL ANTIHISTAMINES (below are some common antihistamines)**

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

*Nasal Sprays: **Astelina**, **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)

***You will need to bring your completed New Patient Packet (attached), all insurance cards, a government issued photo ID and a list of all medications you take (both prescription and over the counter, include strength and dose).**

*All appointments can take up to *two (2) hours*, please allow enough time in your schedule. You will need to arrive *15 minutes prior to your scheduled appointment* to complete the check in process and 30 minutes prior if your paperwork is not complete. Patient's arriving late may have to be rescheduled. **Note, minors (anyone under 18) not accompanied by their legal parent/guardian, capable of giving a complete detailed medical history, WILL be rescheduled.**

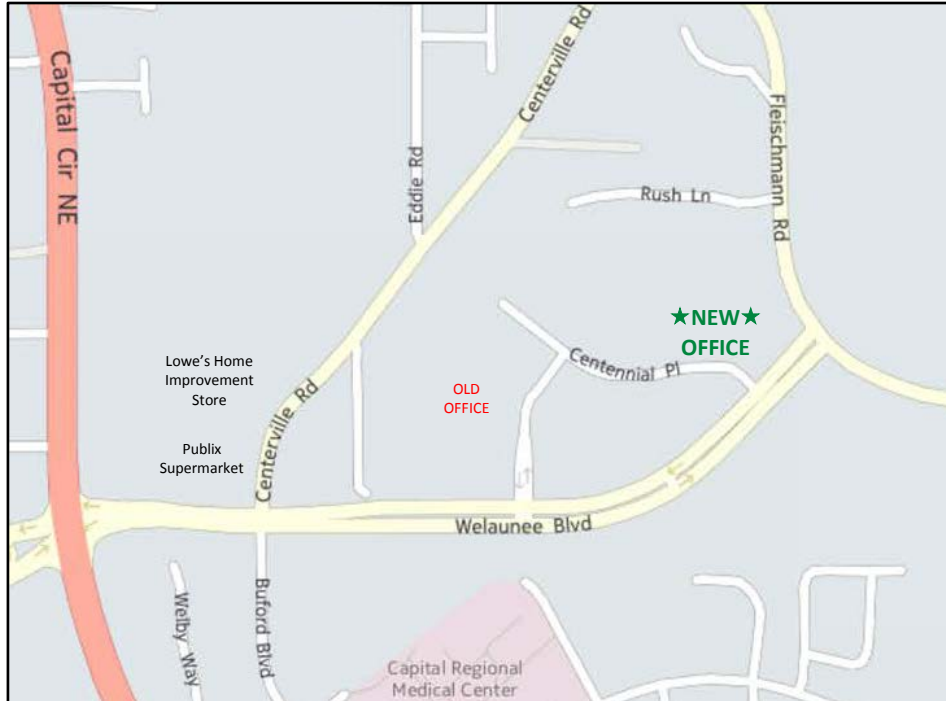
*We treat patients with asthma and food allergies, for their safety we ask that *no food* be brought into the office and *refrain from using cologne, perfumes or scented lotions*.

*Any changes to your appointment (those missed, cancelled or rescheduled) with less than one (1) business days' notice may result in a **\$75 no show/cancellation fee** and you may not 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



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

Call for further directions: (850) 656-7720

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: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
City	Employer Address			
State	Zip	City	State	Zip
Patient Home Phone <input type="checkbox"/> <u>OK to leave messages</u>	Patient Cell Phone <input type="checkbox"/> <u>OK to leave messages</u>	Patient Work Phone <input type="checkbox"/> <u>OK to leave messages</u>		
Pharmacy Name & Location <input type="checkbox"/> <u>OK to verify Rx History Electronically</u>	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	<input type="checkbox"/> <u>Check if Address is same as Patient-IF NOT:</u>	Address	City	State	Zip
Home Phone <input type="checkbox"/> <u>OK to leave messages</u>	Cell Phone <input type="checkbox"/> <u>OK to leave messages</u>	Work Phone <input type="checkbox"/> <u>OK to leave messages</u>			
DOB	SSN	Employer			
<input type="checkbox"/> <u>Check if this person is the insurance policy holder</u>		Employer Address			
<input type="checkbox"/> <u>Check if this person is permitted to receive information on the patient</u>		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	<input type="checkbox"/> <u>Check if Address is same as Patient-IF NOT:</u>	Address	City	State	Zip
Home Phone <input type="checkbox"/> <u>OK to leave messages</u>	Cell Phone <input type="checkbox"/> <u>OK to leave messages</u>	Work Phone <input type="checkbox"/> <u>OK to leave messages</u>			
DOB	SSN	Employer			
<input type="checkbox"/> <u>Check if this person is the insurance policy holder</u>		Employer Address			
<input type="checkbox"/> <u>Check if this person is permitted to receive information on the patient</u>		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
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**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? none red itch watery dry eyelid irritation/rash discharge change in vision

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

Sinus symptoms? none pain pressure headaches fullness infections

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

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

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

ENVIRONMENTAL HISTORY

Where do you currently live? house apartment mobile home dorm

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

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

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

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

IMMUNE SYSTEM

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

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

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

Has the patient had previous pneumonia vaccination? Yes No Unsure

CONSTITUTIONAL SYMPTOMS

none weight loss weight gain loss of appetite fever weakness fatigue

ENT SYMPTOMS

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

sinus pain nasal polyps sinus surgery

RESPIRATORY SYMPTOMS

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

cough

PATIENT REVIEW OF SYSTEMS FORM – PAGE 2

CARDIOVASCULAR

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

OPHTHALMOLOGY

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

ENDOCRINOLOGY

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

GASTROENTEROLOGY

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

UROLOGY

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

DERMATOLOGY

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

NEUROLOGY

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

HEMATOLOGY/LYMPH

none swollen glands fatigue loss of appetite varicose veins easy bruising

MUSCULOSKELETAL

none joint stiffness joint pain joint swelling leg cramps sciatica

PSYCHOLOGY

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

MALE REPRODUCTIVE

none difficulty with erection diminished sexual drive penile discharge

FEMALE REPRODUCTIVE

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

PATIENT REVIEW OF SYSTEMS FORM – PAGE 3

SOCIAL HISTORY

Do you currently smoke? Yes No

Have you smoked in the past? Yes No

Do you drink alcohol? Yes No

Do you use recreational drugs? Yes No

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

Do you consume caffeine? Yes No

Have you traveled outside the US? Yes No

Are you currently sexually active? Yes No

Have you been exposed to any of the following while at work? none animals asbestos cleaning fluids

grain dust industrial chemicals strong odors other

TALLAHASSEE ALLERGY, ASTHMA & IMMUNOLOGY - DR. CRUZ PATIENT SYMPTOM ASSESSMENT FORM

Patient Name: _____ Person filling out form (relation): _____

SECTION A: NOSE, SINUS, EAR AND EYE SYMPTOMS (Upper Respiratory)

Note: If no upper respiratory problems, check here and go to next Section B (lower respiratory)

<input type="radio"/> sneezing <input type="radio"/> itchy nose <input type="radio"/> nasal congestion/stuffiness	<input type="radio"/> itchy eyes <input type="radio"/> red, watery eyes <input type="radio"/> swollen eyelids
<input type="radio"/> runny nose: if so, what color: <input type="radio"/> clear <input type="radio"/> yellow/green <input type="radio"/> bloody	<input type="radio"/> dark circles <input type="radio"/> deviated nasal septum
<input type="radio"/> post nasal drip <input type="radio"/> sore throat <input type="radio"/> nose bleeds	<input type="radio"/> sinus xrays or CT scan: if so, when? _____ results: <input type="radio"/> normal <input type="radio"/> abnormal
<input type="radio"/> decreased or absent sense of smell <input type="radio"/> snoring	<input type="radio"/> ENT evaluation: if so, when? _____ Name of doctor: _____
<input type="radio"/> nasal polyps: <input type="radio"/> Yes <input type="radio"/> No if so, has surgery been performed, when? _____	<input type="radio"/> fatigue/tired <input type="radio"/> poor concentration <input type="radio"/> throat itching
<input type="radio"/> recurrent ear infections <input type="radio"/> ears plugging/fullness/popping	<input type="radio"/> hoarseness <input type="radio"/> poor sleep
<input type="radio"/> recurrent sinus infections: how many last year? _____	<input type="radio"/> others: _____

Symptoms are aggravated by (check ALL that apply): tobacco smoke cold air animals odor/scents/fragrance
 weather changes temperature changes pollens yard work musty odors/mold dusting/vacuuuming
 being outdoors aspirin/related medications others: _____

Symptoms began at age: ____ Symptoms are: improving worsening same † Symptoms interfere with: sleep work/school activity
Year round symptoms: Yes No Symptoms are worse in: Spring Summer Fall Winter

List all medications used for upper respiratory symptoms (include over-the-counter medicines and nasal sprays):

Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat

SECTION B: LOWER RESPIRATORY SYMPTOMS (CHEST, LUNG PROBLEMS)

Note: If no lower respiratory problems, check here and go to next Section C (skin problems)

<input type="radio"/> cough, chronic or recurrent: if so, cough is: <input type="radio"/> dry <input type="radio"/> loose † <input type="radio"/> coughing spells mucus is: <input type="radio"/> clear <input type="radio"/> yellow green <input type="radio"/> bloody	<input type="radio"/> asthma diagnosed by doctor age diagnosed: ____
<input type="radio"/> shortness of breath <input type="radio"/> difficulty getting a full breath	# of ER visits in last year: ____ Last ER visit Date: _____
<input type="radio"/> wheezing <input type="radio"/> awakening at night with chest symptoms	# of Times Hospitalized: ____ Date Last Hospitalized: _____
<input type="radio"/> nighttime cough <input type="radio"/> chest tightness or pressure	# of Times in Intensive Care: ____ On ventilator? <input type="radio"/> Yes <input type="radio"/> No
Frequency of coughing, wheezing or shortness of breath: <input type="radio"/> Daily <input type="radio"/> Twice per week <input type="radio"/> More than twice a week	asthma not diagnosed but: <input type="radio"/> frequent bronchitis
<input type="radio"/> oral corticosteroid prescriptions: if so, # of times in last year ____	<input type="radio"/> respiratory "trouble" as child <input type="radio"/> has nebulizer machine or inhaler
<input type="radio"/> history of recurrent bronchitis <input type="radio"/> history of recurrent pneumonia	<input type="radio"/> previous chest xray or CT scan: if so, when? _____ results: <input type="radio"/> normal <input type="radio"/> abnormal
	<input type="radio"/> previous pulmonary function test: <input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> pulmonary/lung doctor evaluation: when? _____ Name of doctor: _____

Symptoms are aggravated by (check ALL that apply): tobacco smoke cold air animals odor/scents/fragrance
 weather changes temperature changes pollens yard work musty odors/mold dusting/vacuuuming
 being outdoors aspirin/related medications others: _____

Symptoms began at age: ____ Symptoms are: improving worsening same † Symptoms interfere with: sleep work/school activity
Year round symptoms: Yes No Symptoms are worse in: Spring Summer Fall Winter

List all medications used for lower respiratory symptoms (include over-the-counter medicines and inhalers):

Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat

SECTION C: SKIN PROBLEMS

Note: If no skin problems, check here and go to next Section D (food allergies/intolerances)

<input type="radio"/> itching <input type="radio"/> excessively dry/scaly skin <input type="radio"/> recurrent skin infections <input type="radio"/> welts/hives: if so, when did it start? _____ location of hives? _____ triggers: <input type="radio"/> occur for no reason <input type="radio"/> heat <input type="radio"/> cold <input type="radio"/> pressure against skin <input type="radio"/> stress <input type="radio"/> exercise <input type="radio"/> foods: _____ <input type="radio"/> eczema: if so, when did it start? _____ location? _____	<input type="radio"/> skin swelling: if so, when did it start? _____ Location? <input type="radio"/> face <input type="radio"/> lips <input type="radio"/> tongue/throat <input type="radio"/> hands <input type="radio"/> feet <input type="radio"/> genitalia Frequency of skin problem symptoms: <input type="radio"/> daily: times per week ____ times per month ____ other: _____ <input type="radio"/> dermatologist evaluation: if so, when? _____ Name of doctor: _____
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List all medications used for skin problems (include over-the-counter medicines):

Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat
Name of Medicine: _____	<input type="radio"/> Past <input type="radio"/> Current	Did it help? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat

SECTION D: FOOD ALLERGY/INTOLERANCES

Note: If no food allergy/intolerances, check here and go to next Section E (insect sting reactions)

FOOD:	REACTIONS NOTED:	AGE:	COMPLETELY AVOIDED:
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No

SECTION E: INSECT STING REACTIONS

Note: If no insect sting reactions, check here and go to next Section F (previous testing)

If yes, insect(s) causing reaction: _____

Symptoms(check ALL that apply): Large swelling at site Hives/swelling Breathing problems
 Dizziness/lightheadedness/paleness Others, list: _____

When did this occur? _____ Epinephrine device prescribed? Yes No

SECTION F: PREVIOUS TESTING

Previous Allergy Evaluation(s): Yes No Name of doctor(s) & year: _____

Has skin prick testing been done? Yes No

Positive reactions to: none tree pollens grass pollens weed pollens dust mite cat dog
 molds foods others _____

Have you been on allergy shots? Yes No Date or year started and for how long? _____
Were they effective? Yes No Did you have any serious reactions to allergy shots? Yes No

Briefly state symptoms for coming to see us here: _____

Notes: