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, asthma or food allergies*** 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/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)

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). Payment expected at time of service.

*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!

****Due to COVID19** face masks are required for entry in the building. Do not come in if you have been ill or exposed to someone that has been ill or has COVID19. No visitors are allowed to come with patients to their appointments. For minors, only one parent will be permitted. If you have a rescue inhaler, please bring it with you to your appointment.

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

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

Patient First Name | DOB | Referring Physician & Phone Number

Previous Name | Gender | ☐ Single ☐ Married ☐ Widowed ☐ Divorced Marital Status

Patient Home Address | SSN | Employment/Student Status: ☐ Full-time ☐ Part-time

City | Patient Employer/School Name

State | Zip | Employer Address/City/State/Zip

Patient Phone ☐ **Cell** ☐ **Work** ☐ **Home** ☐ **OK to leave messages on this phone**

Race: ☐ White ☐ Black/AA ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Asian Indian ☐ Other: _____

Patient Phone ☐ **Cell** ☐ **Work** ☐ **Home** ☐ **OK to leave messages on this phone**

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Pharmacy Name & Location ☐ **OK to verify Rx History Electronically**

Email Address (if patient is a minor list parent's, only one email address can be added to a chart)

Additional Contact Info-Such as a Parent (if Minor MUST HAVE) or Spouse or Emergency Contact:

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

First & Last Name | Relationship to Patient | DOB | SSN

☐ **Cell** ☐ **Work** ☐ **Home** ☐ **OK to leave messages on this phone**

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

If Parent of a Minor, or Insurance Policy Holder: Employer Name/Address/City/State/Zip

☐ **Check if this person is permitted to receive information on the patient**

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

Additional Contact Info-Such as a Parent (if Minor MUST HAVE) or Spouse or Emergency Contact:

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

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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 1 business days' 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? ☐ 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

OPTHALMOLOGY

☐ 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 (cigarettes, e-cigarettes, vape, juul, hookah, marijuana, cigar, pipe)? ☐ 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

Please list all medications you are taking, both prescription and over the counter, below:

Name of Medication	Strength	Dosing/Schedule