

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

*Heartburn Medicines: **Zantac** (Ranitidine), **Pepcid** (Famotidine), **Axid** (Nizatidine), **Tagamet** (Cimetidine)

*Misc.: **Phenergan** (promethazine), **Meclizine**

***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.**

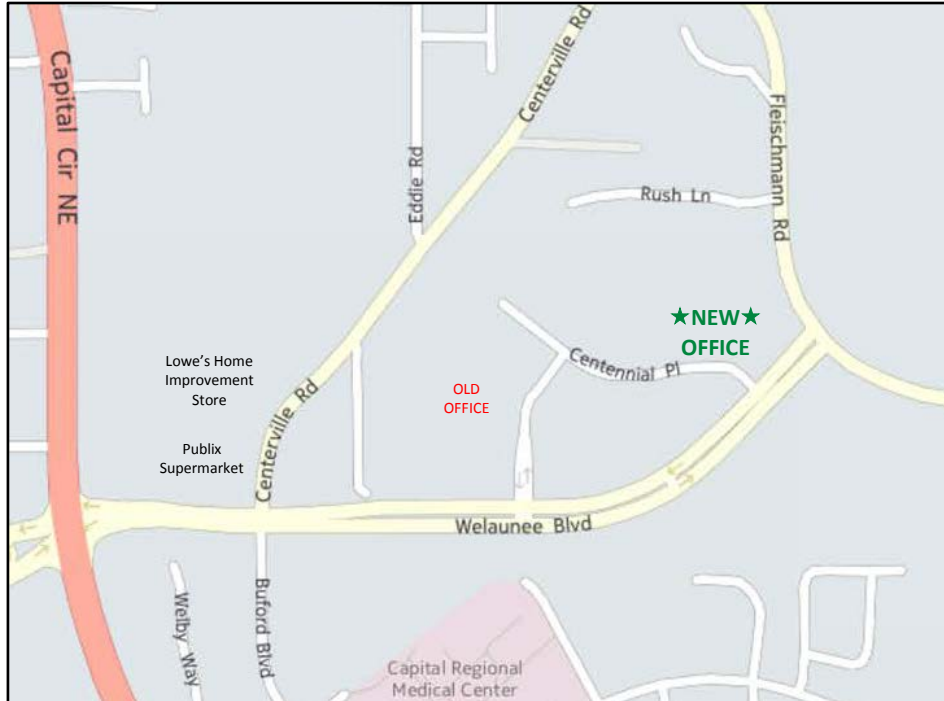
*Any changes to your appointment (those missed, cancelled or rescheduled) with less than one (1) business days' notice may result in a **\$75 no show/cancellation fee** and you may not be rescheduled.

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



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

_____ Patient Last Name	_____ Middle Initial	_____ Primary Care Physician & Phone Number
_____ Patient First Name	_____ DOB	_____ Referring Physician & Phone Number
_____ Previous Name	_____ Gender	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Marital Status
_____ Patient Home Address	_____ SSN	Employment/Student Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
_____ City	_____ Patient Employer/School Name	
_____ State	_____ Zip	_____ Employer Address/City/State/Zip
_____ Patient Phone <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> OK to leave messages on this phone		Race: <input type="checkbox"/> White <input type="checkbox"/> Black/AA <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other: _____
_____ Patient Phone <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> OK to leave messages on this phone		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
_____ Pharmacy Name & Location <input type="checkbox"/> 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
_____ <input type="checkbox"/> OK to leave messages on this phone		_____ <input type="checkbox"/> OK to leave messages on this phone	
<input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home		<input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home	
<input type="checkbox"/> 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

<input type="checkbox"/> Check if this person is permitted to receive information on the patient	<input type="checkbox"/> Check if this person is the insurance policy holder
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Additional Contact Info-Such as a Parent (if Minor MUST HAVE) or Spouse or Emergency Contact:

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

<input type="checkbox"/> Check if this person is permitted to receive information on the patient	<input type="checkbox"/> Check if this person is the insurance policy holder
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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
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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

