

**Nose/Sinus/Breathing Questionnaire**

Florida Medical Clinic Allergy, Asthma & Immunology

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To be filled out by the patient or the parent/guardian of the minor child. The following questions will help to determine the cause of your allergy and/or asthma symptoms. It is important to answer each question to the best of your knowledge and as accurately as possible.

**Patient’s Name** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Sex\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Briefly describe the reason for your allergy visit and what you hope to accomplish?

YOUR SYMPTOMS**: *Please check all that applies to you. Check None if it does not apply.***

**Constitutional,** □ none, other: **Nose/Allergic,** □ none, other:

□ Weight: (Circle One) Gain or Loss □ Less sense of smell

If so how much? \_\_\_\_\_ what time frame \_\_\_ □ Snoring

**Endocrine,** □ none, other: □ Discharge (Circle One)

□ More tired than normal □ Clear / Discolored

**Skin,** □ none, other: □ Thin / Thick

 □ Dryness, itching □ Constant / Seasonal

 □ Eczema □ Itching, rubbing

**Head/Neurologic,** □ none, other: □ Stuffiness (constant / seasonal)

□ Headache (sinus/other \_\_\_\_\_) □ Nose bleeds, last episode? \_\_\_\_\_

**Respiratory/Cardiovascular** **,** □ none, other: □ Sneezing, how many times in a row? \_\_\_\_\_

 Wheeze (with rest / with activity)

 □ Night, nights per week? \_\_\_ **Throat/Allergic,** □ none, other:

 □ With exercise or laughter □ Itch

□ Cough (day/ night, with exercise) □ Trouble swallowing

□ Dry □ Productive, color? □ Clearing throat, hoarseness

 □ Day □ Post nasal drip (clear/ white/ other) Circle One

 □ Night, nights per week? \_\_\_ □ Sore throat

 □ With exercise or laughter **Ears/Allergic,** □ none, other:

□ Shortness of breath □ Popping or congestion

□ Chest tightness □ Itching

□ Chest symptoms per week, \_\_\_ days

**Eyes,** □ none, other: **Stomach,** □ none, other:

□ Itching, rubbing □ Heartburn, reflux, GERD

 □ Redness, puffiness, discharge Times per week? \_\_\_\_

**Lymphatic,** □ none, other: **Psychiatric,** □ none, other:

□ Swollen glands?, where? \_\_\_\_\_\_ □ Anxiety

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Physician’s Signature Date \_\_ Q\_\_ P/\_\_ O \_\_ C

YOUR MEDICAL HISTORY

Heart trouble? Yes No If yes, what type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other serious medical problems, please list:**

YOUR CURRENT MEDICATIONS

***Please ALL your medications. Please bring in actual medication bottles.***

***Medication Dose (mg) How many times a day*** ­­­­­

|  |  |  |
| --- | --- | --- |
| ***1.*** |  |  |
| ***2.*** |  |  |
| ***3.*** |  |  |
| ***4.*** |  |  |
| ***5.*** |  |  |
| ***6.*** |  |  |
| ***7.*** |  |  |
| ***8.*** |  |  |

YOUR ENVIRONMENT

HOME

How old is your home?

How long have you lived in home?

Did the previous owner have pets? Yes No If Yes, Types?

Air Conditioning: Central Window unit None

Current or recent pets? Yes No

 What type and how many?

 Are they Inside Outside Both (inside at times)

How old is your mattress? \_\_\_\_\_\_ years, How old is your pillow? \_\_\_\_\_\_years

Which rooms have carpeting?

None Living room Your Bedroom Other

Does your home have any obvious mold growth, musty smell, past floods or water leaks? Yes No

Does anyone smoke in the house or car? Yes No

Which state were you born in, and how long did you live there?

How long have you lived in Florida?

WORK

Do you work mostly: Indoors Outdoors Both

Exposures: Animal dander, if so which: Chemicals: which: Moldy or Musty smells