

**Rash/Swelling 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?

**OTHER POSSIBLE SYMPTOMS: *Are you currently or recently experiencing any of these problems***

**Mouth 1.**  Open sores in your mouth?: Yes No

If so painful or painless?

**Skin 2.**  Rash on your cheeks? Yes No

**3.**  Rash that is worse when you are in the sun? Yes No

 **4.** Other skin (other than the above problem) or hair changes? Yes No

 If so, please specify:

**Musculoskeletal 5.** Joints that hurt or are swollen? Yes No

**6.** Feel stiff in the morning, if so for how many hours? Yes No

**7.** Hand swelling? Yes No

**Lymph nodes 8.**  Swollen glands or lymph nodes, if so where? Yes No

**Respiratory 9.** Sharp chest pain when you breathe in deep? Yes No

**Urinary 10.**  Blood in your urine? Yes No

**Endocrine 11.** Unusual weight gain or weight loss? Yes No

**Constitutional 12.** Night sweats not associated with menopause? Yes No

**13.** More fatigue than normal? Yes No

**Gastrointestinal 14.** Heartburn, reflux or GERD symptoms Yes No

 If so how many times a week ? \_\_\_\_\_\_\_\_\_

**Allergic 15.** Hay fever type symptoms? Yes No

**Neurologic/ Psychiatric 16.** Headaches? Yes No

 **17.** Anxiety? Yes No

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Provider’s Signature Date \_\_ Q \_\_P/ \_\_ O \_\_ C

YOUR MEDICAL HISTORY

Heart trouble? Yes No

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

YOUR CURRENT MEDICATIONS

***Please list names of ALL your medications and include dose and how frequent medication is taken***

***Please also 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?

What type of home: House? Apartment?

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

Current or recent pets? Yes No

 What type and how many?

 Are they Inside Outside Both (inside at times)

Are there any home exposure(s)/trigger(s) which seems to aggravate your rash?

WORK

Do you work mostly: Indoors Outdoors Both

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

Are there any home exposure(s)/trigger(s) which seem to aggravate your rash?