

**ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES OF TAMPA BAY**

www.allergytampa.com

**RICHARD F. LOCKEY, M.D. ROGER W. FOX, M.D. DENNIS K. LEDFORD, M.D. MARK C. GLAUM, M.D., Ph.D.**

**Please complete front and back of form.**

DATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ CIRCLE: MR. MRS. MS. MISS

CIRCLE: MALE / FEMALE DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

STREET ADDRESS & APT. # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # ( ) \_\_\_\_\_ CELL # ( ) \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

PATIENT'S PLACE OF EMPLOYMENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WORK TELEPHONE # ( ) \_\_\_\_\_ EXT. # \_\_\_\_\_

(IF PATIENT IS UNDER 18, PLEASE COMPLETE)

PARENT OR GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME TELEPHONE # ( ) \_\_\_\_\_ WORK TELEPHONE # ( ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ TELEPHONE # ( ) \_\_\_\_\_

PRIMARY PHYSICIAN'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

TELEPHONE # ( ) \_\_\_\_\_

RELATIONSHIP TO YOU \_\_\_\_\_

WORK TELEPHONE # ( ) \_\_\_\_\_

**Present all insurance / pharmacy cards to the receptionist.**

**INSURANCE # 1 - PRIMARY**

NAME OF INSURANCE CO. \_\_\_\_\_

HMO  PPO OTHER \_\_\_\_\_

CO. ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_

MEMBER # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

POLICY HOLDER'S SSN \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

POLICY HOLDER'S DATE OF BIRTH \_\_\_\_\_

COPAY OR PERCENTAGE OF AMOUNT \_\_\_\_\_

**INSURANCE # 2 - SECONDARY**

NAME OF INSURANCE CO. \_\_\_\_\_

HMO  PPO OTHER \_\_\_\_\_

CO. ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_

MEMBER # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

POLICY HOLDER'S SSN \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

POLICY HOLDER'S DATE OF BIRTH \_\_\_\_\_

COPAY OR PERCENTAGE OF AMOUNT \_\_\_\_\_

\*Please Note That Workers' Compensation Cases must Be Preauthorized by Management.

over →

**ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES OF TAMPA BAY**

**www.allergytampa.com**

**RICHARD F. LOCKEY, M.D.    ROGER W. FOX, M.D.    DENNIS K. LEDFORD, M.D.    MARK C. GLAUM, M.D., Ph.D.**

If you have a medication prescription plan, please complete:

Name of pharmacy company \_\_\_\_\_

ID# \_\_\_\_\_ Phone # \_\_\_\_\_

**AUTHORIZATIONS**

1. CONSENT FOR MEDICAL TREATMENT: I AUTHORIZE ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY (AAIATB) TO FURNISH THE NECESSARY MEDICAL TREATMENTS, PROCEDURES, DRUGS, AND SUPPLIES AS ORDERED. I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT, DIAGNOSTIC PROCEDURES, AND EXAMINATIONS.
2. STATEMENT OF FINANCIAL RESPONSIBILITY: I HEREBY AGREE TO PAY AAIATB FOR ALL CHARGES (TO INCLUDE CO-PAYS, DEDUCTIBLES, PERCENTAGES, AND HEALTH SAVINGS ACCOUNTS) AT THE TIME OF SERVICE; HOWEVER, I UNDERSTAND THAT AAIATB MAY ACCEPT ASSIGNMENT OF INSURANCE BENEFITS IN LIEU OF EQUAL AMOUNT OF PAYMENT. THE FULL AMOUNT OF ALL CHARGES NOT PAID BY THE INSURANCE COMPANY WILL ULTIMATELY BE MY RESPONSIBILITY. I REALIZE THAT IF A BALANCE IS DUE NECESSITATING THE USE OF A COLLECTION AGENCY, I AGREE TO PAY ALL COLLECTION COSTS, INCLUDING ATTORNEY FEES AND FEES ON APPEAL.
3. OUR BILLING AND COLLECTION PROCEDURES REQUIRE THAT THE SOCIAL SECURITY NUMBER OF THE INSURED/RESPONSIBLE PARTY BE PROVIDED.
4. NOTICE OF PRIVACY OF PROTECTED HEALTH INFORMATION RECEIVED AND CONSENT IS GIVEN TO RELEASE MEDICAL RECORDS TO OTHER HEALTH CARE PHYSICIANS.

**WELCOME, WHY DID YOU SELECT OUR PRACTICE?** (Complete as applicable)

- REFERRED BY DR. \_\_\_\_\_     REFERRED BY MY INSURANCE COMPANY
- REFERRED BY ANOTHER PATIENT \_\_\_\_\_     ADVERTISEMENT (circle one) our website / phonebook / internet

DATE \_\_\_\_\_ PATIENT OR GUARDIAN'S SIGNATURE \_\_\_\_\_

## ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY

**Richard F. Lockey, M.D.**  
**Roger W. Fox, M.D.**  
**Dennis K. Ledford, M.D.**  
**Mark C. Glaum, M.D., Ph.D.**  
**13801 Bruce B. Downs Boulevard, Suite 502**  
**Tampa, Florida 33613 - (813) 971-9743**  
**Billing: Ext. 111**  
**www.allergytampa.com**

### FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we will work with you. The fo

- Our office participates in a variety of insurance plans. **It is your responsibility to:**
  - **Bring your insurance card at each visit.**
  - **Be prepared to pay your co-pay, deductible, or co-insurance at the time services are rendered, to include high deductible health plans (HSA). Payment can be made by cash, check, or we accept Visa and Master Card.**
  - **Payment in full is expected at the time services are rendered.**
- If you have insurance with which we are not contracted, we will file the claim if you have out-of-network benefits, any deductible or co-insurance that you are responsible for is due at the time of service. If your insurance does not provide out-of-network benefits, then you are responsible for payment in full.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance based on hardship guidelines. Please so inform us prior to your visit. Financial hardship cases are for patients without medical insurance.
- Referrals: It is your responsibility to provide required referrals prior to the visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible for payment in full.
- If the patient is 18 years or younger, the patient's legal guardian must sign below. When a minor is seen, all the same rules and regulations apply.
- A \$50.00 charge is assessed to patients who do not cancel a scheduled appointment within 48 hours or do not come for their visit (no-shows).

Our practice firmly believes that a good physician/patient relationship is based on understanding and good communications. Questions about financial arrangements should be directed to the front office.

**I have read and understand this financial policy.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-Responsible Party

\_\_\_\_\_  
Date

*Richard F. Lockey, M.D.*  
*Roger W. Fox, M.D.*  
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Adult and Pediatric  
Allergy, Asthma and Immunology

Diplomates American Board  
of Allergy and Immunology

13801 Bruce B. Downs Blvd.  
Suite 502  
Tampa, FL 33613  
813/971-9743

**ACKNOWLEDGMENT**

I, (print patient's name) \_\_\_\_\_, acknowledge that I have received a copy of the Notice Regarding Privacy of Personal Health Information from Allergy, Asthma and Immunology Associates of Tampa Bay.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Height \_\_\_\_\_ Weight \_\_\_\_\_

**ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES OF TAMPA BAY****Richard F. Lockey, M.D.****Roger W. Fox, M.D.****Dennis K. Ledford, M.D.****Mark C. Glaum, M.D., Ph.D.****13801 Bruce B. Downs Boulevard, Suite 502****Tampa, Florida 33613 - (813) 971-9743****www.allergytampa.com****MEDICAL HISTORY AND ALLERGY SURVEY**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF PERSON COMPLETING FORM IF NOT COMPLETED BY PATIENT \_\_\_\_\_

NAME OF PRIMARY CARE PHYSICIAN (PCP) \_\_\_\_\_ + \_\_\_\_\_

NAME OF REFERRING PHYSICIAN (IF OTHER THAN PCP) \_\_\_\_\_

**INSTRUCTIONS:** YOU MUST COMPLETE THIS FORM. OUR INSURANCE REQUIRES THAT IT BE DONE. **YOU WILL NOT BE SEEN UNLESS IT IS COMPLETED.** THERE ARE **8** PAGES. PLEASE COMPLETE ALL PAGES.

1. **CHIEF COMPLAINT:** What are the main symptoms which are bothering you?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. **NOSE, THROAT, AND SINUSES:**

Do you or did you ever have nose, throat, or sinus problems? Yes \_\_\_ No \_\_\_ If yes, answer below; if no, go to #3.

When did you first have trouble with your nasal symptoms? What age were you? \_\_\_\_\_ Season? \_\_\_\_\_

Check the following symptoms that you are having

- |  |                                 |
|--|---------------------------------|
| ___ sneezing                                 | ___ hoarseness                  |
| ___ itching of the nose or roof of the mouth | ___ decreased smell             |
| ___ nose rubbing                             | ___ decreased taste             |
| ___ clear nasal discharge                    | ___ itchiness inside ears       |
| ___ post nasal drip                          | ___ nose bleeding               |
| ___ colored nasal discharge                  | ___ snore                       |
| ___ frequent nose blowing                    | ___ sore throat in the morning  |
| ___ nasal stuffiness                         | ___ you clear your throat often |
| ___ mouth breathing                          | ___ heartburn                   |
| ___ frequent throat clearing                 | ___ wake up with heartburn      |
| ___ sore throat                              | ___ belch a lot                 |
| ___ yellow or green discharge in your throat |                                 |

Do some of your nasal symptoms occur almost every day throughout the year? Yes \_\_\_ No \_\_\_

Are your nasal symptoms worse during any particular season or time of day?

i.e., (1) mild, (2) moderate, or (3) severe (fill in number):

January _____	May _____	September _____
February _____	June _____	October _____
March _____	July _____	November _____
April _____	August _____	December _____

Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_ Night \_\_\_\_\_ All \_\_\_\_\_ CONTINUE TO NEXT PAGE

Have you ever had any of the following problems? (Check)

Yes \_\_\_ No \_\_\_ sinus infection

Yes \_\_\_ No \_\_\_ nasal polyps

Yes \_\_\_ No \_\_\_ frequent headaches - Where? front \_\_\_ temples \_\_\_ eyes \_\_\_ back \_\_\_

If yes, do you frequently chew gum? Yes \_\_\_ No \_\_\_ Have you had braces? Yes \_\_\_ No \_\_\_

Yes \_\_\_ No \_\_\_ aspirin induced nasal symptoms

Yes \_\_\_ No \_\_\_ nasal surgery - When? \_\_\_\_\_ Last? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ frequent "bad colds"

Yes \_\_\_ No \_\_\_ frequent tonsillitis - How many times per year? \_\_\_\_\_

Check one of the following statements that best describes the severity of your nasal symptoms when they are at their worst:

\_\_\_ mild                      \_\_\_ severe  
\_\_\_ moderate                \_\_\_ very severe

How many school or work days have you missed in a year's time due to these problems?

\_\_\_\_\_

What medicines have you taken to control your eye and/or nose symptoms?

\_\_\_\_\_

Are you taking any of these medicines every day? \_\_\_\_\_

\_\_\_\_\_

Generally, how much relief from your symptoms do you get by taking these medicines?

\_\_\_ Excellent    \_\_\_ Good    \_\_\_ Moderate    \_\_\_ Very little    \_\_\_ None

What nose drops or sprays are you using? \_\_\_\_\_

Have you had a CAT scan of your sinuses? Yes \_\_\_ No \_\_\_ When \_\_\_\_\_

**3. EARS:** Have you ever had any of the following ear symptoms? (Check)

Yes \_\_\_ No \_\_\_ If no, go to #4.

Yes \_\_\_ No \_\_\_ frequent ear infections

Yes \_\_\_ No \_\_\_ are you dizzy?

How many within the past year? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ are you lightheaded?

Yes \_\_\_ No \_\_\_ is your hearing impaired

**4. EYES:** Have you had any of the following eye symptoms ? (Check)

Yes \_\_\_ No \_\_\_ If no, go to #5.

Yes \_\_\_ No \_\_\_ itching

Yes \_\_\_ No \_\_\_ light hurts your eyes

Yes \_\_\_ No \_\_\_ redness

Yes \_\_\_ No \_\_\_ yellow discharge from eyes

Yes \_\_\_ No \_\_\_ tearing

Yes \_\_\_ No \_\_\_ eyelid swelling

Yes \_\_\_ No \_\_\_ dryness

Yes \_\_\_ No \_\_\_ eyelid irritation

Yes \_\_\_ No \_\_\_ burning

How often have these symptoms been a problem within the past year?

Circle correct answer: never; some; a lot; extreme.

**5. LUNGS:** If you do or have had asthma, please answer the questions.

If you have never had wheezing or lung problems, you may skip this question and proceed to #6.

When did you first begin to have wheezing spells?

Age? \_\_\_\_\_ Season? \_\_\_\_\_

CONTINUE TO NEXT PAGE

Check the following symptoms you are having:

Yes \_\_\_ No \_\_\_ mild to moderate wheezing episodes  
 Yes \_\_\_ No \_\_\_ severe wheezing episodes  
 Yes \_\_\_ No \_\_\_ does this limit your exercise or play?  
 Yes \_\_\_ No \_\_\_ during or after exercise?

Is your wheezing worse during any particular months or time of day? (Mark yes or no)

January _____	May _____	September _____
February _____	June _____	October _____
March _____	July _____	November _____
April _____	August _____	December _____

Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_ Night \_\_\_\_\_

With your wheezing do you usually have:

\_\_\_\_\_ fever \_\_\_\_\_ cough \_\_\_\_\_ tightness in your chest?

Do you usually have a cold or chest infections when you wheeze?

Can you have a normal "bad cold" without you then developing chest congestion and wheezing? \_\_\_\_\_

How many times during the past year have you had to visit your doctor (or hospital emergency room) because of your wheezing?

How many times have you been hospitalized due to your wheezing? \_\_\_\_\_

When were you last in the hospital for this? \_\_\_\_\_

How many school or work days have you missed this year due to your wheezing?

What medicines are you taking to control your wheezing? \_\_\_\_\_

Do you use inhaler(s)? \_\_\_\_\_ How often? \_\_\_\_\_

Which one(s)? \_\_\_\_\_

Have you required cortisone (prednisone, Medrol, etc.) drugs for control of your wheezing in the past? Yes \_\_\_ No \_\_\_

How many times? \_\_\_\_\_ Date last used: \_\_\_\_\_

Do you ever have any of the following symptoms? (Check)

Yes ___ No ___ frequent coughing spells	Yes ___ No ___ coughing on exertion
Yes ___ No ___ recurrent night cough	Yes ___ No ___ coughing then wheezing
Yes ___ No ___ coughing up mucus (color? _____)	Yes ___ No ___ coughing with laughing
Yes ___ No ___ shortness of breath with exercise	Yes ___ No ___ coughing with lying down
Yes ___ No ___ blood in mucus	Yes ___ No ___ coughing with talking on the phone

## 6. CHEST INFECTIONS:

As an infant or child, did you have asthma? Yes \_\_\_ No \_\_\_

X-rays: Have you had a chest x-ray within 5 years? Yes \_\_\_ No \_\_\_

If so: Date of last chest film \_\_\_\_\_ Where x-ray obtained \_\_\_\_\_

CONTINUE TO NEXT PAGE

**7. ALLERGIC SKIN PROBLEMS:**

Have you ever had eczema? Yes \_\_\_ No \_\_\_ If no, go to # 8.

When last? \_\_\_\_\_

What parts of your skin were affected? Arms \_\_\_\_\_ Legs \_\_\_\_\_ Face \_\_\_\_\_ Body \_\_\_\_\_

**8. PREVIOUS ALLERGY EVALUATIONS:**

Have you ever had an allergy evaluation in the past? Yes \_\_\_ No \_\_\_ If no, go to #9.

If you have, then complete the following questions:

What age were you when you had your first allergy evaluation? \_\_\_\_\_

Which doctor and where? \_\_\_\_\_

If you have had skin testing, to what were you found to be allergic?

\_\_\_ trees            \_\_\_ weeds            \_\_\_ dust            \_\_\_ foods  
 \_\_\_ grasses        \_\_\_ molds            \_\_\_ feathers        \_\_\_ others

If you have received a series of allergy shots in the past, please give the inclusive dates:

\_\_\_\_\_

If you are on allergy shots now, how often are you taking them?

\_\_\_\_\_

What improvement have you (did you) note(d) in your symptoms while on allergy shots:

\_\_\_ marked improvement (almost complete clearing of your symptoms)

\_\_\_ moderate improvement    \_\_\_ no improvement

Did you ever have an allergic reaction to your shots? Yes \_\_\_ No \_\_\_

If yes, what happened? \_\_\_\_\_

\_\_\_\_\_

**9. FACTORS WHICH MAY CONTRIBUTE TO YOUR ALLERGIC PROBLEMS**

In the following questions, 1-7, check the factors that you think will make your nose symptoms or wheezing (asthma) start or become worse. Otherwise, go to #10.

- |     |              |                                |              |
|-----|--------------|--------------------------------|--------------|
| (1) | <u>Lungs</u> | <u>Infections</u>              | <u>Nasal</u> |
| ___ |              | a "viral bad cold"             | ___          |
| ___ |              | a respiratory infection        | ___          |
| (2) |              | <u>Weather</u>                 |              |
| ___ |              | change in weather              | ___          |
| ___ |              | wet, rainy weather             | ___          |
| ___ |              | onset of cold weather          | ___          |
| ___ |              | being in the wind              | ___          |
| (3) |              | <u>Inhalant Allergens</u>      |              |
| ___ |              | playing in or mowing the grass | ___          |
| ___ |              | musty smells                   | ___          |
| ___ |              | exposure to house dust         | ___          |
| (4) |              | <u>Hormone</u>                 |              |
| ___ |              | menstruation                   | ___          |
| ___ |              | pregnancy                      | ___          |
| (5) |              | <u>Physical Factors</u>        |              |
| ___ |              | air conditioning               | ___          |
| ___ |              | cold air                       | ___          |
| ___ |              | getting up in the morning      | ___          |

CONTINUE TO NEXT PAGE

(6) <u>Lungs</u>	<u>Smells</u>	<u>Nasal</u>
_____	exhausts, fumes	_____
_____	smoke	_____
_____	perfumes, cosmetics	_____
_____	cleaning agents	_____
_____	cooking odors	_____
(7) _____	<u>Miscellaneous</u>	
_____	birds	_____
_____	cats	_____
_____	dogs	_____
_____	other animals	_____
_____	feather pillows	_____

**10. INGESTANTS:** Do you know of any foods, drinks, or medicines that will make your nose symptoms or wheezing start or cause it to become worse? (Circle and add items.)

Yes \_\_\_ No \_\_\_ If no, go to #11.

Foods (milk, egg, wheat, nuts, peanut, shellfish, soybean) \_\_\_\_\_

Drinks (beer, wine) \_\_\_\_\_

Medicines (aspirin) \_\_\_\_\_

**11. DRUG ALLERGY:**

Have you ever had an allergic reaction to any of the following drugs?

Yes \_\_\_ No \_\_\_ If no, go to #12.

_____ penicillin	_____ tetracycline	Others _____
_____ sulfa drugs	_____ "mycins" (erythromycin)	_____
_____ aspirin	_____ Levaquin, Cipro, Floxin	_____
_____ Ceclor (cephalosporin)	_____ codeine, morphine, Demerol	_____
_____ tetracycline		

**12. INSECTS:**

Have you ever had an allergic reaction to an insect? Yes \_\_\_ No \_\_\_ If no, go to #13.

_____ bee	_____ yellow jacket	_____ fire ant	_____ other
_____ wasp	_____ hornet	_____ deer fly	

What happened?

Local swelling Yes \_\_\_ No \_\_\_

Hives, swelling, itching over the entire body Yes \_\_\_ No \_\_\_

Other \_\_\_\_\_

When did the last reaction occur? Approximate date \_\_\_\_\_

CONTINUE TO NEXT PAGE

**ENVIRONMENTAL FACTORS If does not apply, go to #14.**

(1) Location:

(X) Where your symptoms are worse. (✓) where your symptoms are better.

\_\_\_\_\_ indoors \_\_\_\_\_ outdoors \_\_\_\_\_ at home \_\_\_\_\_ at school or at work  
 \_\_\_\_\_ in air conditioning \_\_\_\_\_ away from home \_\_\_\_\_ the same at all locations

(2) Environmental Exposure: Check the following items that best describe your surroundings:

Residence

How long have you lived in your present dwelling? \_\_\_\_\_ years

Bedroom

\_\_\_\_\_ wall-to-wall carpet  
 \_\_\_\_\_ carpets in bedroom, how old \_\_\_\_\_?  
 Type of mattress? Regular \_\_\_\_\_ Water \_\_\_\_\_  
 Type of pillow? Dacron \_\_\_\_\_ Feather \_\_\_\_\_  
 Does your mattress or pillow have airtight covers? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there mold growing in your house? \_\_\_\_\_ If yes, where? \_\_\_\_\_

What kind of animals (birds also) do you have? \_\_\_\_\_

Are they indoors at any time? Yes \_\_\_\_\_ No \_\_\_\_\_ How many years? \_\_\_\_\_

**14. PERSONAL-SOCIAL FACTORS (EVERYONE MUST ANSWER COMPLETELY)**

What is your occupation? \_\_\_\_\_

Does anyone practice any hobbies or occupations in your home that produce vapors, or dust, or strong odors? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

Do you smoke cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_ How many cigarettes per day? \_\_\_\_\_

Did you ever smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ How long? \_\_\_\_\_ years. Average of how many packs per day? \_\_\_\_\_

Does anyone smoke in your home? Yes \_\_\_\_\_ No \_\_\_\_\_ How many persons? \_\_\_\_\_

Do you abuse alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_ More than 2-3 drinks per day? \_\_\_\_\_

Do you use illicit drugs (confidential)? Yes \_\_\_\_\_ No \_\_\_\_\_

**15. FAMILY HISTORY (EVERYONE MUST ANSWER COMPLETELY)**

	living/deceased Father	living/deceased Mother	How many? Brothers	How many? Sisters	How many? Children
Does any of your family have any of the following illnesses? (Check)					
Hay fever					
Asthma					
Eczema					
Hives					
Sinus trouble					
Any other illnesses?					

Is any family member deceased? \_\_\_\_\_ Cause? \_\_\_\_\_

Do any illnesses seem to run on your father's or mother's side of the family?

Diabetes, hypertension, heart disease, stroke, other? \_\_\_\_\_

**16. PAST HISTORY (EVERYONE MUST ANSWER COMPLETELY)**

(1) Have you ever had any of the following illnesses?

<input type="checkbox"/> tuberculosis	<input type="checkbox"/> pneumonia	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones
<input type="checkbox"/> ulcer disease	<input type="checkbox"/> rheumatic heart disease	<input type="checkbox"/> diabetes	<input type="checkbox"/> liver disease
<input type="checkbox"/> heartburn	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> hypertension	<input type="checkbox"/> high risk for AIDS
<input type="checkbox"/> cancer	<input type="checkbox"/> radiation therapy	<input type="checkbox"/> blood transfusion	<input type="checkbox"/> sleep apnea

(2) What surgery have you had? (tonsillectomy, nasal surgery, etc.) Approximate dates:

---



---



---

(3) Have you had any serious illness or injuries which led to hospitalization?

Yes  No  List type and year: \_\_\_\_\_

---

(4) Have you received the Pneumovax vaccine? Yes  No  Do not know (5) Do you receive the yearly flu vaccine? Yes  No  Do not know 

Please list all medications you take and the dose, including over-the-counter medications:

(1) \_\_\_\_\_ (6) \_\_\_\_\_

(2) \_\_\_\_\_ (7) \_\_\_\_\_

(3) \_\_\_\_\_ (8) \_\_\_\_\_

(4) \_\_\_\_\_ (9) \_\_\_\_\_

(5) \_\_\_\_\_ (10) \_\_\_\_\_

**REVIEW OF SYSTEMS (EVERYONE MUST ANSWER COMPLETELY)**

Do you have any of the following at this time? (Check)

General

weight loss  
 chills  
 fevers  
 loss of appetite  
 fatigue  
 poor memory  
 fall asleep during the day  
 snoring is a problem

Skin

rashes on feet  
 rashes in groin  
 rashes between legs  
 rashes between toes

Musculoskeletal

morning joint stiffness and aching  
 painful, swollen joints  
 muscle tenderness or pain  
 muscle weakness

Gynecological

excess bleeding  
 change in menstrual cycle

Gastrointestinal

nausea  
 vomiting  
 diarrhea  
 change in bowel habits  
 trouble swallowing (food gets stuck)  
 heartburn  
 black bowel movements  
 blood in bowel movement

Cardiovascular

chest pain  
 chest pain with exercise  
 calf pain with exercise  
 ankle swelling

CONTINUE TO NEXT PAGE

Endocrine

- cold intolerance
- heat intolerance

Kidney

- trouble starting urine
- bed wetting
- burning with urination
- loss of urine with cough or sneeze
- frequent urination during the night

Blood

- bleed or bruise easily
- swollen lymph nodes

Neurological

- weakness/clumsiness
- tingling, burning, or numbness of extremities

Psychological

- fearful, anxious
- excessive worry
- crying spells
- trouble sleeping
- behavior problems
- depression

Other

- lumps or bumps under arms
- lumps or bumps in breasts

Sleepiness Scale - Are you sleepy during the day? If so, complete the following using the appropriate numbers.

- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Chance of dozing

Situation of dozing / falling asleep

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- Sitting and reading
- Watching television
- Sitting inactively in a public place (such as a theater or meeting)
- As a passenger in a car for an hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car, while stopped for a few minutes in traffic

Please add anything you wish which the questionnaire did not address.

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To the best of my knowledge, I have answered the complete questionnaire.

\_\_\_\_\_ Signature

Reviewed form with the patient in its entirety.

\_\_\_\_\_  
Richard F. Lockey, M.D.

\_\_\_\_\_  
Mark C. Glaum, M.D., Ph.D.

## ASTHMA CONTROL TEST (ACT)

**This form must be completed by the patient to comply with insurance requirements / documentation.**

Please circle **ONE** answer for each of the **5** questions below and review your results with your physician.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work or at home?

All of the time	<b>1</b>	Most of the time	<b>2</b>	Some of the time	<b>3</b>	A little of the time	<b>4</b>	None of the time	<b>5</b>
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2. During the past 4 weeks, how often have you had shortness of breath?

More than once a day	<b>1</b>	Once a day	<b>2</b>	3 to 6 times a week	<b>3</b>	Once or twice a week	<b>4</b>	Not at all	<b>5</b>
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3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night, or earlier than usual in the morning?

4 or more nights a week	<b>1</b>	2 to 3 nights a week	<b>2</b>	Once a week	<b>3</b>	Once or twice	<b>4</b>	Not at all	<b>5</b>
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4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	<b>1</b>	1 to 2 times per day	<b>2</b>	2 or 3 times per week	<b>3</b>	Once a week or less	<b>4</b>	Not at all	<b>5</b>
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5. How would you rate your asthma control during the past 4 weeks?

Not controlled at all	<b>1</b>	Poorly controlled	<b>2</b>	Somewhat controlled	<b>3</b>	Well controlled	<b>4</b>	Completely controlled	<b>5</b>
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**TOTAL SCORE \_\_\_\_\_ (please enter score on the other side of this form)**

If your total score is 19 or less, your asthma may not be as well controlled as it could be.

**YOU MAY PRINT THIS FORM PRIOR TO YOUR VISITS BY ACCESSING  
[www.allergytampa.com/medlist](http://www.allergytampa.com/medlist)  
THIS FORM MUST BE COMPLETED BY THE PATIENT BEFORE SEEING THE DOCTOR  
TO COMPLY WITH INSURANCE REQUIREMENTS / DOCUMENTATION**

\_\_\_\_ RICHARD F. LOCKEY, M.D.  
\_\_\_\_ DENNIS K. LEDFORD, M.D.

\_\_\_\_ ROGER W. FOX, M.D.  
\_\_\_\_ MARK C. GLAUM, M.D., Ph.D.

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

And/or circle items if applicable: Routine visit    Need refills    Sneezing    Runny nose    Itchy eyes    Cough  
Wheeze    Asthma    Respiratory infection    Sinusitis    Headache    Fever    Earache    Discolored discharge

NEW PROBLEMS SINCE LAST VISIT: \_\_\_\_\_

PREVIOUS PROBLEMS: STABLE \_\_\_\_\_ OR WORSENING (describe) \_\_\_\_\_

LIST ALL MEDICATIONS AND THE DOSE PRESCRIBED TO YOU BY ALL PHYSICIANS WHICH YOU TAKE.

NOTE: WE CAN ONLY REFILL MEDICATIONS PRESCRIBED TO YOU BY US.

<u>MEDICATION</u>	<u>DOSE</u>	<u>TIMES TAKEN IN A DAY</u>	<u>✓ REFILLS</u> (only if needed)
1) _____			
2) _____			
3) _____			
4) _____			
5) _____			
6) _____			
7) _____			
8) _____			
9) _____			
10) _____			

PRESCRIPTIONS ARE HANDWRITTEN TO TAKE TO YOUR PHARMACY OR MAIL ORDER.  
WE DO NOT CALL IN OR FAX PRESCRIPTIONS FROM OUR OFFICE.

IF YOU MAIL YOUR PRESCRIPTIONS, DOES YOUR INSURANCE REQUIRE A 90 DAY SUPPLY ? \_\_\_\_\_  
OR, DO YOU FILL YOUR PRESCRIPTIONS AT A LOCAL PHARMACY ? \_\_\_\_\_

ANY ALLERGIES TO MEDICATIONS \_\_\_\_\_

**have asthma? complete reverse side of form - ACT SCORE \_\_\_\_\_**

FOR MEDICAL STAFF:

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ PF \_\_\_\_\_ TEMP \_\_\_\_\_