

Date: _____ Patient: _____

DOB: _____

COMPLETED BY: (circle) Patient Spouse Parent/Guardian

Primary care provider? _____ What city? _____

Reason for visit? (circle) Annual visit Rx Renewal New Problem – Began: _____

Describe: _____

ON ALLERGY SHOTS: No ___ Yes ___ How Long? _____

Satisfaction (circle) - Excellent Good Fair Poor Improvement (0-100%) _____

Office where shots are received? _____ City _____

IF YOU HAVE ASTHMA:

Have you been hospitalized or in the ER for asthma since last visit? Yes ___ No ___

Can you be physically active without cough/wheeze, shortness of breath? Yes ___ No ___

Prednisone since last visit? Yes ___ No ___

ASTHMA CONTROL TEST: Please circle the best answer.

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

All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5)

2. During the past 4 weeks, how often have you had shortness of breath?

More than once/day (1) Once per day (2) 3-6 times a week (3) Once or twice/week (4) Not at all (5)

3. During the past 4 weeks, how often did your asthma symptoms wake you up at night or earlier than usual in the morning?

4 or more nights per week (1) 2-3 nights/week (2) Once per week (3) Once or twice/month (4) Not at all (5)

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times/day (1) 1-2 times/day (2) 2-3 times/week (3) Once per week (4) Not at all (5)

5. How would you rate your asthma control during the past 4 weeks?

Not controlled (1) Poor control (2) Somewhat controlled (3) Well-controlled (4) Completely controlled (5)

PERSONAL HISTORY:

Occupation? _____ Smoker? _____ How many years? _____ Packs per day? _____

Year Stopped _____ Other smokers in home? _____

Medication allergies? (list) _____

Describe reaction: _____

Medications for asthma / allergy:

_____ Dose & frequency: _____

_____ Dose & frequency: _____

_____ Dose & frequency: _____

Other Meds taken, daily or as needed:

_____ Dose & frequency: _____

_____ Dose & frequency: _____

_____ Dose & frequency: _____

_____ Dose & frequency: _____

REVIEW OF SYSTEMS (√ if present in past 1-2 weeks)

1. **GENERAL:** none fever sweats weight change

2. **ALLERGY:** none hay fever sinus problem gland swelling PETS (see below)
 other: _____

IF PETS: # dogs in the home: _____ inside or outside? (circle) bathed? Y N
cats in the home: _____ inside or outside? (circle) bathed? Y N

3. **SKIN:** none rash hives unusual mole

4. **EYES:** none itch glaucoma/cataract vision change

EARS: none plugged infection ringing dust mite encasings

5. **NOSE:** none sneezing bleeding polyps Hot water washing

MOUTH: none soreness hoarseness toothache Bedroom carpeted? Y N

6. **LUNGS:** none cough wheeze sputum production HEPA filter in home

7. **HEART:** none chest pain murmur leg swelling HEPA filter in bedroom

8. **ABDOMEN:** none vomiting bloody stool heartburn/reflux Air-conditioning

9. **URINARY:** none burning bloody urine prostate problem Dehumidifier

10. **PSYCH:** none depression anxiety mood swings

11. **OTHER:** _____

PAST HISTORY: In last five years have you had:

Circle: Major illness Surgery Food allergy Drug allergy Bee sting allergy **None**

Other _____ MD/NP _____

Name _____ DOB _____ Date _____

(II) ● HEIGHT: _____ (% _____) WEIGHT _____ (% _____) BP (sitting) _____ Pulse _____ T _____ RR _____
RN/MA _____

CC / HPI / Annual
Progress _____

- **GEN:** _____ well developed / well nourished / atopic facies
grooming / deformities

- **EYES:** Conjunctiva: Clear / Red / Cobblestoning / Glasses / Contacts
Lids: N / Red / Edema / Infraorbital edema / Discoloration / Dennie-Morgan folds
Pupils PERRLA

- **SINUS:** Nontender / Tender / Masses ● **CARDIAC:** RRR / Murmur (SEM, DM) / Displaced PMI

- **EARS:** Canal: Clear / Red / Cerumen / Hearing Aids
TM: Normal / Retracted / Red / Bubble / Fluid / Sclerosis / Tubes

- **VASCULAR:** Intact / Pulses / Edema / varicosities -hands -feet

- **NOSE:** Passages: patent / ↓ R L / polyp / nasal crease ● **GI:** Soft / Nontender / Mass / Obese / Bowel Sounds
Septum: straight / R L / perforation
Turbinate: pink / red / blue / pale / boggy / edematous
Secretion: clear / purulent / blood / wet / dry / moist
Sniffing / Sneezing

- **ORGANS:** N / Hepatomegaly / Splenomegaly

- **SKIN:** Visual: Clear / Hives / Eczema / Lichenified / Excoriated

- **ORO:** Clear / Tonsils / PLH / PND / Red Palpate: Dermatographic / Xerosis / Edema
Mouth-breather / Throat-clearing / Thrush Hyperkeratosis Pilaris / Dermatographism

- **TEETH** Intact / Dentures / Gums - pink - pale ● **MOOD:** Normal / Depressed / Anxious/Agitated / Crying

- **NECK:** Clear / LN / Trachea midline ● **PSYCH:** Oriented to time / place / person / Age approp.

- **THYROID:** Normal / Enlarged / Tender / Mass ● **EXTREMITIES:** N/ Clubbing/ Cyanosis/ Infection
Deformity / Tremor

- **LUNG:** Clear / Cough / Wheeze/ Forced FEW/ Rale / Rhonchi ↓ BS

- **GAIT:** N / Limp / Wheelchair / Cane / Walker

- **EFFORT:** Normal / Accessory Muscles / Retractions

- Other _____

- **LYMPHATICS:** Normal / Neck / Auricular pre post

ASSESSMENT / PLAN

___ Asthma - Intermittent / Persistent / CONTROL: W / NW / VP Lo Risk / Hi Risk Spirometry ↑ ↓ NML

Restriction Obstruction

ICS Green _____ Yellow _____

Rescue _____

Other _____

Action Plan in Chart _____

___ Cough _____

___ Allergic Rhinitis OTC AH _____ Nasal Steroid _____
Irrigation _____ Other _____

___ Allergic Conjunctivitis _____

___ Sinusitis Acute/Chronic Plan: Afrin Irrigation Nasal Steroid Decongestant Antibiotic

___ Food Allergy _____ Epi Avoid

Action Plan in Chart _____

___ Venom Allergy Epi Avoid VIT Action Plan in Chart _____

___ Atopic Derm Stable Flaring Skin Care _____

___ Angioedema / Urticaria Stable / Flaring AH Singulair Epi

___ HTN ___ GERD ___ Latex Allergy ___ Smoking Cessation

___ Avoidance Mite Dander Pollen Mold Food Venom

IT: Reactions Reviewed - Local / Systemic / Fatality / Technique / Compliance Q 1-2 Q 1-4 Q 1-6

Revisit _____ Face to Face Time _____

MD/C-NP _____