

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 Estimated 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

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? (Circle) 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) Score []
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 (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 (3) Well-controlled (4) Complete (5) control []

PERSONAL HISTORY:

Occupation? _____ Smoker? _____ How many years? _____ Packs per day? _____ Year Stopped _____ Other smokers home? _____

Medication allergies? (list) _____ Describe reaction _____

Table with 4 columns: Medications for asthma/allergy, Dose & frequency, Other Meds taken, daily or as needed, Dose & frequency.

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

- (III) 1. GENERAL: fever, sweats, weight change, none
(IV) 2. ALLERGY: hay fever, sinus problem, gland swelling, none
3. SKIN: rash, hives, unusual mole, none
4. EYES: itch, glaucoma/cataract, vision change, none
EARS: plugged, infection, ringing, none
5. NOSE: sneezing, bleeding, polyps, none
MOUTH: soreness, hoarseness, toothache, none
6. LUNGS: cough, wheeze, sputum production, none
7. HEART: chest pain, murmur, leg swelling, none
8. GI: Foods stick in throat, vomiting, bloody stool, heartburn, none
9. URINARY: burning, bloody urine, prostate problem, none
(V) 10. PSYCH: depression, anxiety, mood swings, none

HOME ENVIRONMENT

(Circle) PETS: Dogs # ___ Cats # ___ Other ___
Inside Outside Bathed
Dust mite encasings Yes No
Hot water washing Yes No
Bedroom carpeted Yes No
HEPA filter in home Yes No
HEPA filter in bedroom Yes No
Air-conditioning Yes No
Dehumidifier Yes No
Other _____

PAST HISTORY: In last five years have you had:

Circle: Major illness Surgery Food allergy Drug allergy Bee sting allergy None Other _____

Family History of allergy: ___ Yes ___ No

Name _____ DOB _____ Date _____

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

CC / HPI / Annual Progress _____

Please circle the number that describes the skin on each part of your or your child's body. Please circle any and all that apply :

	Clear	Dry	Scaly	Redness	Cracks/ Openings	Oozing
Head	0	1	2	3	4	5
Neck	0	1	2	3	4	5
Trunk	0	1	2	3	4	5
Arms	0	1	2	3	4	5
Hands	0	1	2	3	4	5
Legs	0	1	2	3	4	5
Feet	0	1	2	3	4	5
TOTAL:						<input type="text"/>

Please circle the number that describes the intensity of itching associated with your eczema. Please circle only one:

	None	A little bit bothered	Somewhat bothered	Quite bothered	Very bothered	Extremely bothered/sleep loss
Head	0	1	2	3	4	5
Neck	0	1	2	3	4	5
Trunk	0	1	2	3	4	5
Arms	0	1	2	3	4	5
Hands	0	1	2	3	4	5
Legs	0	1	2	3	4	5
Feet	0	1	2	3	4	5
TOTAL:						<input type="text"/>

OVERALL SCORE: /70

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 _____