			_ DATE OF	BIRTH:		DATE:		
Form completed by ( Reason for visit? (circ					e provider? Describe:		-	
Estimated Improve	ment (0-100%): <u>-</u>		where shots ar	e received?	tisfaction (circle): E			Poo
F YOU HAVE ASTHM	<b>MA -</b> Have you be ally active withou	een hospitalized or	in the ER for as	sthma since yo	our last visit?		st visit? 🗌 Yes	с П N <b>Sco</b>
(1) All the time 2. During the past 4	(2) Most of the ti <b>4 weeks, how ofte</b>	me (3) Some of the	e time (4) A l	little of the time <b>h?</b>			or home?	
<b>3. During the past</b> (1) 4 or more nigh	<b>4 weeks, how ofte</b> nts per week (2)	<b>2-3 nights/week</b>	<b>ms wake you uj</b> (3) Once per we	<b>p at night or ea</b> eek (4) Once	e a week (5) Not at rlier than usual in the e or twice (5) Not at medication (such as a	<b>morning?</b> all		
5. How would you r	ate your asthma	mes/day (3) 2-3 tin <b>symptom control du</b> ol (3) Somewhat co	ring the past 4	weeks?	<ul><li>(5) Not at all</li><li>(5) Complete Control</li></ul>	bl		
	es? (list)			Describ	Year stopped? e reaction: tions, daily or as ne			
EVIEW OF SYSTEM	•	·				HON	TE ENVIRONM (circle)	ENT
Fever Sweats Heat intolerance	EARS Plugged ears Multiple infections Decreased hearing Negative	NOSE Plugged nose Multiple infections Congested Sneezing Runny nose	THROAT Congested Sore throat Hoarseness Negative Other:		CARDIOVASCULAR Chest tightness High blood pressure Negative Other:	Inside How often	Cats #Oth e Outside Ba are they bathed? YES in bedroom?	thed

Ρ	rn۱	лd	er:	
	101	/IQ	<b>CI</b> .	-

PATIENT NAME: \_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

TOTAL:

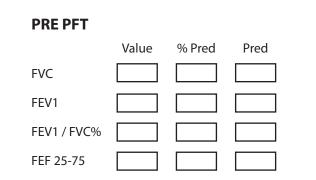
/ 35

## 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

## 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: / 35
					OVER	ALL SCORE: / 70
STAFF USE			)			
Height:	(%) We	ight:(%	BP (sitti	ng) Pu	ilseI	RR RN/MA
CC / HPI / Annu	ual Progress					
	5					



## **POST PFT**

