NAME:______________________________

Date of Appointment:________________

AGE:___________

ID (For Office Use Only):___________.

RETURN VISIT (12 years and older)

Main Reason for visit:
__ Reevaluation
__ Symptoms worse
__ New problem
__ Yearly follow up
__ Follow up/Office Visit

Family Doctor: _______________

Main Concern(s):
__ Allergy eye-ear-nose & throat problems
__ Medication allergy
__ Asthma/Breathing problems
__ Insect sting allergy
__ Food allergies
__ Other: ________________________________
__ Recurring infections
__ Skin problems/Eczema

*********IF YOU ARE NOT ON ALLERGY SHOTS PLEASE SKIP THIS SECTION AND MOVE TO PAGE 2*********

Are you currently on allergy shots: __ Yes __ No

Allergy shots started: _______________________

Are symptoms increased by the time your next shot is due: __ Yes __ No

Dose:
__ 0.30 – 1:1
__ 0.50 – 1:1
__ 0.40 – 1:10
____

How often do you take Shots:
__ Twice weekly
__ Weekly
__ Every 2 weeks
__ Every 3 weeks
__ Every 4 weeks
__ Every 6 weeks

Other: ___________________________

Where do you receive allergy shots:
__ Little Rock
__ Pine Bluff
__ Bryant
__ North Little Rock
__ Primay Care Physician

Any shot reactions since last visit: __ Yes __ No

Have symptoms improved on shots: __ Yes __ No __ Unsure

How much have symptoms improved since starting allergy shots: __ 25% __ 50% __ 75% __ 100%

Have you had any of the following since last visit:

New medication allergies: ________________________________
Received Pneumonia vaccine: __ Yes __ No __ I don't know
Month/Year ________
Flu shot in past year: __ Yes __ No __ I don't know
Month/Year ________
New medical problems: ________________________________
New food allergies: ________________________________
New surgeries: ________________________________
Other: ________________________________

Social History

Smoking status:
__ Current every day smoker
__ Current some day smoker
__ Former smoker
__ Never smoker
__ Unknown if ever smoked
__ Smoker – current status unknown

Smoking type: __ Cigar __ Cigarettes __ Pipes Other: ______________
Smoking duration: __ N/A __ 1-5 years __ 6-10 years __ 11-20 years __ Over 20 years
Maximum packs per day: __ ½ __ 1 __ 1 ½ __ 2 or more
Second hand smoke exposure: __ No __ Inside __ Outside

Medication Use Summary

Allergy nasal spray: ____
Oral allergy meds: ____
Preventative inhaled asthma meds: ____
Preventative oral asthma meds: ____
Asthma rescue inhaler: ____
Eczema creams/ointments: ____
Preventative/Prophylactic antibiotics: ____
How many times have you taken antibiotics in the past 12 months: __ 0 __ 1 __ 2 __ 3 __ 4 __ 5+

Infections That Have Occurred In Past 12 Months

__ None
__ Viral upper respiratory infection
__ Bronchitis
__ Ear infection
__ Sinusitis
__ Tonsillitis
__ Pneumonia
__ Other infection ____________
__ Skin infection

Medication Name (pills, inhalers, sprays, creams, shots)	Strength/Dose	How Many	How Many Times a Day

Allergy Symptoms Since Last Visit

Active problems or symptoms: __ Yes __ No known problem

IF NO KNOWN PROBLEMS SKIP BELOW

Cough: ____
Stuffiness: ____
Runny nose: ____
Post nasal drip: ____
Nasal itch: ____
Eye itch: ____
Tearing: ____
Sneezing: ____
Eczema: ____
Hives: ____
Fever: ____
Clear nasal drainage: ____
Colored nasal drainage: ____
Sinus tenderness: ____
Headache: ____
Sore throat: ____
Earache: ____
Ear Drainage: ____
Fatigue: ____
Sputum: ____
Shortness of breath: ____
Wheezing: ____
Chest tightness: ____
Other: ________________________________

What are the worst seasons:

__ Year round
__ Spring
__ Summer
__ Fall
__ Winter

Long Term Course

How would you rate your long term improvement:
__ Worse __ Somewhat better __ Fully controlled __ N/A
Eye, Ear, Nose & Throat Problems:
__ Worse __ Somewhat better __ Fully controlled __ N/A
Asthma or Chest problems:
__ Worse __ Somewhat better __ Fully controlled __ N/A
Hives:
__ Worse __ Somewhat better __ Fully controlled __ N/A
Eczema:
__ Worse __ Somewhat better __ Fully controlled __ N/A
Headaches:
__ Worse __ Somewhat better __ Fully controlled __ N/A
Sinus infections:
__ Worse __ Somewhat better __ Fully controlled __ N/A

Eczema Status Since The Last Visit
__ N/A
__ Well controlled most of the time using creams/ointments only occasionally
__ Well controlled most of the time using creams/ointments once or twice a day
__ Partially controlled most of the time using creams/ointments once or twice a day
__ Not controlled most of the time using creams/ointments once or twice a day
__ Frequently a problem but creams/ointments are used occasionally or not at all

Hives Status Since Last Visit
__ N/A
__ Well controlled most of the time using medications only occasionally
__ Well controlled most of the time using medications once or twice a day
__ Partially controlled most of the time using medications once or twice a day
__ Not controlled most of the time using medications once or twice a day
__ Frequently a problem but medications are used only occasionally or not at all

Review of Systems (Current or within the last 12 months)

General:
[ ] No Problems
[ ] Fevers
[ ] Chills
[ ] Sweats
[ ] Poor Appetite
[ ] Fatigue
[ ] Malaise
[ ] Weight loss
[ ] See HPI

Heart:
[ ] No problems
[ ] Chest pains
[ ] Congenital heart disease
[ ] Palpitations
[ ] Passing out
[ ] Murmur
[ ] Difficulty breathing on exertion
[ ] See HPI

Urinary Tract:
[ ] No problems
[ ] Pain on urination
[ ] Discharge
[ ] Urinary frequency
[ ] Bed wetting
[ ] Urinary infections
[ ] Urinary stones
[ ] See HPI

Hematologic/ Lymphatic:
[ ] No problem
[ ] Swollen glands
[ ] Easy bleeding or bruising
[ ] See HPI

Skin:
[ ] No problems
[ ] Rash
[ ] Suspicious lesions
[ ] Dryness
[ ] Itching
[ ] Boils
[ ] Hives
[ ] Eczema
[ ] See HPI

Musculoskeletal:
[ ] No problems
[ ] Back pain
[ ] Joint pain
[ ] Joint swelling
[ ] Muscle cramps
[ ] Muscle weakness
[ ] Stiffness
[ ] Arthritis
[ ] See HPI

Neurologic:
[ ] No problems
[ ] Paralysis
[ ] Weakness
[ ] Seizures
[ ] Passing out
[ ] Tremors
[ ] Dizziness
[ ] See HPI

Gastrointestinal:
[ ] No problems
[ ] Heartburn/GERD
[ ] Difficulty swallowing
[ ] Nausea
[ ] Vomiting
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Change in bowel habits
[ ] Jaundice
[ ] See HPI

Metabolic:
[ ] No problems
[ ] Cold intolerance
[ ] Heat intolerance
[ ] Excessive drinking
[ ] Excessive eating
[ ] Excessive urination
[ ] Unexplained weight change
[ ] See HPI

Psychiatric:
[ ] No problems
[ ] Hyperactivity
[ ] Behavior problems
[ ] Depression
[ ] Anxiety
[ ] See HPI

IF YOU ARE NOT HERE FOR ASTHMA RELATED SYMPTOMS PLEASE DO NOT COMPLETE

Are you having (Asthma) breathing problems: ___ Yes ___ No
How many years have you had symptoms: ___ less than 1 ___ 1-3 ___ 4-10 ___ 11-30 ___ over 30
Tend of asthma severity: __ Unchanged __ Improving __ Worsening
Steroid (Prelone, Pediapred, Prednisone) bursts in past year: __ 0 __ 1-2 __ 3-5 __ 6-10 __ over 10

Please answer yes or no to each of the following:

ER visits for asthma in past year: ___Yes ___ No How many in past year: ________
Hospitalized for asthma in past year: ___ Yes ___ No How many in past year: ________
Intensive care unit for asthma: ___ Yes ___ No
Does patient have peak flow meter: ___ Yes ___ No
Had a chest X-ray in the past year: ___ Yes ___ No
If yes: ___ Normal ___ Abnormal

Please indicate if you have had any of the following treatments:
If you did have the treatment, please indicate if it was helpful or not helpful.

Oral steroids (prednisone) or steroid shot in past:	___ No	___ Yes-Helpful	___Yes-Not helpful
Inhaled steroids (Pulmicore, Asmanex, Flovent, etc.):	___ No	___ Yes-Helpful	___ Yes-Not helpful
Combination inhalers (Advair, Symbicort, Fulera, etc):	___ No	___ Yes-Helpful	___ Yes-Not helpful
Singulair:	___ No	___ Yes-Helpful	___ Yes-Not helpful
Home nebulizer machine:	___ No	___ Yes-Helpful	___ Yes-Not helpful
Spacer device (attachment for inhaler):	___ No	___ Yes-Helpful	___ Yes-Not helpful
Rapid-acting inhalers (Albuterol, Prventil, Proair, Ventolin, etc.):	___ No	___ Yes-Helpful	___ Yes-Not helpful

IF YOU ARE NOT HERE FOR ASTHMA RELATED SYMPTOMS PLEASE DO NOT COMPLETE

Are you being treated for Asthma: ___ Yes ___ No

Patient is 12 years or older

How much of a problem is your asthma when you run, exercise or play sports:

___ It's a big problem – I can't do what I want
___ It's a problem and I don't like it
___ It's a little problem but it's OK
___ It's not a problem

During the past 4 weeks:
Have you missed any work or school due to asthma: ___ Yes ___ No

How much of the time did your asthma keep you from getting as much done at work, school, or at home:

___ All of the time
___ Most of the time
___ Some of the time
___ A little of the time
___ None of the time

How often have you had shortness of breath:

___ More than once a day
___ Once a day
___ 3-6 times a week
___ Once or twice a week
___ Not at all

How often did you 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
___ 2 or 3 nights a week
___ Once a week
___ Once or twice
___ Not at all

How often have you used your rescue inhaler or nebulizer medication (such as albuterol):

___ 3 or more times per day
___ 1 or 2 times per day
___ 2 or 3 times per week
___ Once a week or less
___ Not at all

How would you rate your asthma control:

___ Not controlled at all
___ Poorly controlled
___ Somewhat controlled
___ Well controlled
___ Completely controlled