NAME:_____

Date of Appointment:_____

AGE:_____

ID (For Office Use Only):_____.

RETURN VISIT (Children 11 & younger)

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

Patient is 4-11 years old (Please have child answer next 4 questions)

How is your asthma today:

___ Very bad
___ Bad
___ Good
___ Very good

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 to do
___ It's a problem and I don't like it
___ It's a little problem but it's OK
___ It's not a problem

Do you cough because of your asthma:

___ Yes – all of the time
___ Yes – most of the time
___ Yes – some of the time
___ No - none of the time

Do you wake up during the night because of asthma:

___ Yes – all of the time
___ Yes – most of the time
___ Yes – some of the time
___ No – none of the time

During the past 4 weeks, on average, how many days(Answer by parent or care giver)

Did your child have any daytime asthma symptoms:

___ None
___ 1-3 days/month
___ 4-10 days/month
___ 11-18 days/month
___ 19-24 days/month
___ every day

Did your child wheeze during the day because of asthma:

___ None
___ 1-3 days/month
___ 4-10 days/month
___ 11-18 days/month
___ 19-24 days/month
___ every day

Did your child wake up during the night because of asthma:

___ None
___ 1-3 days/month
___ 4-10 days/month
___ 11-18 days/month
___ 19-24 days/month
___ every day