NAME:_____ AGE:_____

Date of Appointment:_____ ID (For Office Use Only):_____.

RETURN VISIT Date of Visit: _____

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 __ Insect sting allergy __ Recurring infections
__ Medication allergy __ Food allergies __ Skin problems/Eczema
__ Asthma/Breathing problems __ Other: _____

***********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 – 1:100
__ 0.50 – 1:100
__ 0.40 – 1:1000
_____

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

Using allergy nasal spray:	__ Occasionally	__ Regularly	__ No	__ N/A
Using oral allergy meds:	__ Occasionally	__ Regularly	__ No	__ N/A
Using preventative inhaled asthma meds:	__ Occasionally	__ Regularly	__ No	__ N/A
Using preventative oral asthma meds:	__ Occasionally	__ Regularly	__ No	__ N/A
Using asthma rescue inhaler:	__ Occasionally	__ Regularly	__ No	__ N/A
Using eczema creams/ointments:	__ Occasionally	__ Regularly	__ No	__ N/A
Preventative/Prophylactic antibiotics:	__ Yes	__ No		
How many times have you taken antibiotics in the past 12 months:	__ 0	__ 1	__ 2	__ 3 __ 4 __ 5+

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:	__ Severe	__ Moderate	__Mild	__ None
Stuffiness:	__ Severe	__ Moderate	__Mild	__ None
Runny nose:	__ Severe	__ Moderate	__ Mild	__ None
Post nasal drip:	__ Severe	__ Moderate	__ Mild	__ None
Nasal itch:	__ Severe	__ Moderate	__ Mild	__ None
Eye itch:	__ Severe	__ Moderate	__ Mild	__ None
Tearing:	__ Severe	__ Moderate	__ Mild	__ None
Sneezing:	__ Severe	__ Moderate	__ Mild	__ None
Eczema:	__ Severe	__Moderate	__ Mild	__ None
Hives:	__ Severe	__ Moderate	__ Mild	__ None
Fever:	__ Severe	__ Moderate	__ Mild	__ None
Clear nasal drainage:	__ Severe	__ Moderate	__ Mild	__ None
Colored nasal drainage:	__ Severe	__ Moderate	__ Mild	__ None
Sinus tenderness:	__ Severe	__ Moderate	__ Mild	__ None
Headache:	__ Severe	__ Moderate	__ Mild	__ None
Sore throat:	__ Severe	__ Moderate	__ Mild	__ None
Earache:	__ Severe	__ Moderate	__ Mild	__ None
Ear Drainage:	__ Severe	__ Moderate	__ Mild	__ None
Fatigue:	__ Severe	__ Moderate	__ Mild	__ None
Sputum:	__ Severe	__ Moderate	__ Mild	__ None
Shortness of breath:	__ Severe	__ Moderate	__ Mild	__ None
Wheezing:	__ Severe	__ Moderate	__ Mild	__ None
Chest tightness:	__ Severe	__ Moderate	__ Mild	__ None
Other:	_____			

What are the worst seasons:

__ Year round
__ Spring
__ Summer
__ Fall
__ Winter

Long Term Course

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

Allergy Symptoms Since The Last Visit
__ Problems only at peak times
__ No problems or symptoms
__ Very symptomatic all the time
__ Well controlled with meds
__ Mild chronic problems

Asthma Symptoms Since The Last Visit
__ ER visit or hospitalization
__ No need for rescue
__ Exercise induced symptoms
__ Generally doing well
__ Flares with allergy exposures
__ Often in yellow zone
__ Flares with weather changes
__ Flares with infections
__ Symptomatic all the time
__ Flares easily managed

Infections That Have Occurred In Past 12 Months
__ None __ Ear infection __ Tonsillitis __ Other infection _____
__ Viral upper respiratory infection __ Sinusitis __ Pneumonia __ Skin infection
__ Bronchitis

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
[ ] Failure to thrive
[ ] 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
[ ] Blood in the urine
[ ] 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
[ ] Bone 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
[ ] Bloody stool
[ ] 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
Trend 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 (Pulmicort, Asmanex, Flovent, etc):	__ No	__ Yes-Helpful	__ Yes-Not Helpful
Combination inhalers (Advair, Symbicort, Dulera, etc):	__ No	__ Yes-Helpful	__Yes-Not Helpful
Singulair, Accolate, or Zyflo:	__ 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, Proventil, 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 to
__ 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 your 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

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 becasue of your 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