**Returning patients - office visit**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **What is your chief concern regarding your allergies today?** |
|  |

If you are still having allergy symptoms, which months are worse? [circle] SAME ALL YEAR

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

**Exposures that make your symptoms worse** (please check all that apply):

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | outdoors |  | indoors | |  | at work | | |  | around cats | |
|  | dry windy days |  | at home | |  | moldy areas | | |  | around dogs | |
|  | mowing grass |  | house dust | |  | chemicals | | |  | exertion | |
| other [please describe]: | | | | |  |  | | |  |  | |
| **Medications Please list all** medications you take daily:     |  | | --- | |  | | **Any new medical problems or surgeries**? |   Updates on your environment:  Does your home have….. | | | | | | | | | | | | | |
|  | Pets? yes ☐ no ☐ If yes, what kind?  central air conditioning? yes ☐ no ☐  central heat? yes ☐ no ☐  wall to wall carpeting? yes ☐ no ☐ | | | previous uncorrected water damage? yes ☐ no ☐  areas of visible mold growth? yes ☐ no ☐  indoor hot tub / area of high humidity? yes ☐ no ☐ | | | | | | | | | |
| Hobbies, occupational exposures : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Any new food reactions? yes ☐ no ☐  If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Insect sting reactions? yes ☐ no ☐ If yes, to which? bee, wasp, yellow jacket, hornet, fire ant, other: \_\_\_\_\_  Please describe: hives? difficulty breathing? throat swelling? Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |  |
| Active ‘eczema’]? yes ☐ no ☐ If yes, current treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Medication reactions? yes ☐ no ☐ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Immunization reactions? yes ☐ no ☐ If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |

**Review of Systems: Please indicate your current, ongoing symptoms**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Eye Symptoms** | itching |  | burning |  | dark circles |  | glaucoma |  |
| none ☐ | excessive tearing |  | dryness |  | wear contact lenses |  | cataracts |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ear Symptoms:** | itching |  | popping |  | hearing loss |  | frequent infections |  |
| none ☐ | pe tubes |  | congested |  | earache |  | other: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nasal Symptoms** | sneezing |  | runny nose |  | loss of sense of smell |  | broken nose |  |
| none ☐ | itching |  | congestion |  | green/yellow mucous |  | other: |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Oral symptoms**: | hoarseness |  | snoring |  | difficulty swallowing |  |
| none ☐ | throat clearing |  | postnasal drip |  | other: |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Headache** | under eyes |  | forehead |  | migraine |  |
| none ☐ | behind eyes |  | temples |  | other: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Chest symptoms:** | cough |  | shortness of breath |  | tightness |  |
| none ☐ | wheezing |  | excessive mucous |  | other: |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Abdominal:** | heartburn |  | frequent diarrhea |  | frequent constipation |  |
| none ☐ | pain |  | nausea / vomiting |  | other: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Skin symptoms:** | hives |  | itchy skin |  | sensitivity to metals |  |
| none ☐ | swelling episodes |  | eczema |  | other: |  |

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| --- | --- | --- | --- | --- |
| **Cardiovascular** | heart problems |  | chest symptoms with exertion |  |
| none ☐ | hypertension |  | other: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Constitutional:** | fever |  | chills |  | unexplained weight loss |  |

none ☐

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Musculoskeletal:** | joint swelling |  | stiffness or pain |  | limb swelling or pain |  |

none ☐

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Neurological:** | previous stroke |  | other neurologic problems: |  |

none ☐

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Psychiatric:** | emotional problems |  | depression |  | other: |  |

none ☐

|  |
| --- |
| **Are you using tobacco? Yes**  ☐ **No** ☐ |

For patients with asthma:

* Have you had any asthma ‘attacks,’ urgent care or ER visits, or hospitalizations for asthma in the past year? **yes ☐ no ☐** If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What is your current personal best peak flow? \_\_\_\_\_\_\_\_
* Do you have your ‘asthma action plan’ available?  **yes ☐ no ☐**