**Returning patients - office visit**

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

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| --- |
| **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:  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **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 ☐**