Date of Visit: _____ **NEW PATIENT OFFICE VISIT**

Name: _____ Age: _____ DOB: _____ SSN: _____ Referring MD_____
Address: _____ Phone: _____ PMD: _____

Main Reasons for Today's Visit: _____
How often do you have this problem? _____
How long have you had this problem? _____

Allergy and Asthma history, please check all that apply to you. I suffer from the following *year round &/or seasonally*.

__Itchy or Watery eyes __Dry eyes or Red eye __Nasal congestion or Runny nose
__Nasal itch/rubbing __Yellow or green nasal discharge __Sneezing
__Drainage down the throat __Nasal polyps __Headaches
__Excessive Fatigue __Irritability, loss of focus __Loss of smell or taste
__Nose bleeds __Bad breath __Snoring
__Mouth breathing __Coughing __Wheeze
__Shortness of breath __Chest tightness __Asthma (diagnosed ___ years ago)
__Gastric Reflux Disease __Abdominal pain __Diarrhea __Vomiting
__Rashes __Frequent Infections: # of ear infections/year___ # of sinus infections/year__# of pneumonia in lifetime___

If you have **ASTHMA**, answer the following questions:

- How often do you use controller medications? _____ How often do you use rescue medications?_____
- Do you wake up at night because of breathing problems or coughing? Yes No Times per week/month____
- Do you have and use a peak flow meter? Yes No
- Ever required ER care, hospitalization, intubation, ICU care or had pneumonia because of your asthma? Yes N
- Received steroid pills or shots for your asthma? Yes No If yes, how many times in the last year? _____
- Have you had asthma education? Yes No

Please identify your ***triggers*** for **OCULAR/NASAL** symptoms as best as you can:

__Dust __cleaning products __Perfumes (odors) __animals (cat, dog, other___)
__Pollen (fall &/or spring) __Feather __Mold/mildew __weather changes
__Mowing Grass __Heat __Cold __temperature changes
__Rake Leaves __indoors __outdoors __home or work or both
__Rain __foods_____

Please identify your ***triggers*** for **ASTHMA** symptoms as best as you can:

__Pollen __exercise __weather changes __sinus infections __worsening of nasal/sinus symptoms
__Mold __heartburn __animals (cat, dog, other_____) __Foods Other:_____

Have you ever had a Sinus x-ray or CT? Yes No Have you ever had a chest x-ray or CT? Yes No

OTHER ALLERGY HISTORY

Do you have eczema or hives? Yes No
Have you had an abnormal reaction to insect sting? Yes No How old were you? _____
Do you have food allergy? Yes No_____
Do you have drug allergies? Yes No_____
Do you have latex allergy? Yes No_____
Have you ever had allergy testing done? Yes No When? _____ Were you on shots? Yes No When? _____
Did the shots help? Yes No
Are you transferring allergy, asthma, immunotherapy (shots) care? Yes No From_____.

MEDICATIONS:

What are your current allergy/asthma medications? All Other medications:

Name Dose Times used daily/weekly/rarely

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you use a spacer with your asthma inhaler? _____
Do you have a nebulizer at home? _____

ENVIRONMENTAL SURVEY

Primary Residence: House Apartment Condo Trailer Other_____
How long have you lived here_____. How old is it? _____
Any pets? Yes No Cat Dog Other_____
Where does the pet stay? Indoor Outdoor Both
Any smokers in the house? Yes No
Air Conditioned? Yes No If yes, Central or Window?
Carpets/Rugs? Yes No
Lots of Houseplants? Yes No
Do you keep your windows closed? Yes No
Humidifier? Yes No Dehumidifier? Yes No Air filter? Yes No
Basement? Yes No If yes, Damp, Musty, Seepage or Flooding? Yes No
Roaches? Yes No

Bedroom: What type of bed do you have?_____
Stuffed animal? Yes No Carpet? Yes No Any pets in bedroom? Yes No
Type of Bedding? Feather/Cotton/Synthetic Is bedding enchased? Yes No

Other Social History: How long have you lived in GA?_____
Where else have you lived? _____
Change of symptoms on trips or travel _____
How many days of work or school did you miss in last year _____
What is your occupation? _____ Symptoms at work are Better or Worse
What are your hobbies_____
If you are a child, what grade are you in? _____ Do you play sports? _____
Do you go to daycare? Yes No_____

Do you smoke? Yes No Did you ever smoke? _____ (#pk/year_____)
Are you (or were you) exposed to second hand smoke? _____
Do you drink alcohol? Yes No How much? _____
Do you use (or ever used) any illicit drug? Yes No

PAST MEDICAL HISTORY:

Hospitalizations: _____ Surgeries: _____
_____ _____
_____ _____
_____ _____

Ever had Ear Tubes? Yes No Nasal/Sinus Surgery? Yes No Tonsillectomy/adenoidectomy? Yes No
Other medical conditions: Such as high blood pressure, diabetes etc: _____
_____

Are you childhood vaccines up to date? Yes No Do you get flu vaccine? Yes No
Do you get pneumonia Vaccine? Yes No Any adverse reaction to vaccination? Yes No

FAMILY HISTORY: Does any family member have the following?

Asthma Hay fever Eczema Headaches Cystic Fibrosis Cough Hives Lupus
Rheumatoid Other:_____

REVIEW OF SYSTEMS (circle and explain if needed)

- Constitutional: fever fatigue weight change irritability
- Skin: eczema hives ulcers in mouth thrush itching swelling
- Eyes: swelling discharge itching contact lens cataracts glaucoma
- Ears: frequent infections wax build up loss of hearing
- Cardiac: racing chest pain high blood pressure coronary artery disease heart attack
- GI: diarrhea nausea vomiting heart burn liver disease ulcers
- GU: problems with urination blood in urine urinary infections prostate problems
- Musculoskeletal: joint swelling or pain osteoporosis
- Endocrine: thyroid problems female/male hormonal problems
- Neurological: headache seizure migraines stroke
- Psychological: are allergies affecting your mood quality of life
- Hematological: frequent infections HIV anemia bleeding swollen glands

PHYSICAL EXAM Wt_____ Ht_____ P: _____ RR: _____ BP: _____ T: _____

General: WD WN NAD well groomed overweight obese thin

EYES	Conjunctiva	Normal injected swollen Shiners
	Lids	Normal eczema papilla
ENT	Nasal mucosa	Normal pale red swollen blue/boggy
	Nasal discharge	Normal clear yellow/green purulent
	Nasal septum	Normal R deviated L deviated
	Nasal polyps	None R or L small or large
	Orophyarynx	Normal cobblestone PND clear purulent erythema
	Tonsils	Normal exudates enlarged absent
	Teeth/Gums	Normal good fair poor missing dentures
	TMs/Canals	Normal R or L fluid R or L Wax R or L purulence
	Face/Sinus	Normal tender frontal tender maxillary R or L
NECK		Normal thyroid enlarged masses
Lymphatics	Neck/Axilla/Groin	Normal enlarged
CVS	Heart	Normal abnormal rhythm murmur
	PVS	Normal abnormal
Respiratory	Auscultation	Normal wheezing rales rhonchi decreased BS
	Resp. effort	Normal using acc muscles retractions poor
Abdomen		Normal no masses no HSM
Skin		None eczema hives dermatographic lesions other
Neuro		Normal depressed anxious
Extremities		Normal edema cyanosis clubbing
Other		

Peak Flow

PFTs

Pre
FVC__
FEV1___
FEF 25-75
___

Post
FVC____
FEV1___
FEF 25-75___

% change

_____

Assessment	Plan	Other Assessments/Plans
1.		
2.		
3.		

Next Apt:_____