

- Tell us about how bad your cough has been in the last 4 weeks by marking an (X) in the box on the 0-5 scale

	0 None	1 Mild	2	3 Moderate	4	5 Severe
How bad is your cough?						
Cough at bedtime?						
Cough when you first wake up?						
Cough in your sleep?						
Cough after exercise?						
Cough when you talk for prolonged about of time?						
Cough when you laugh?						
Cough when you sing?						
Cough when you cry?						
Cough when you drink or eat something cold?						
Cough when you go outside in the cold weather?						
Cough when you have cold viral infection?						

- When you catch a cold, do you develop a severe cough: Yes No
- How long does the cough last? _____
- How often does it occur in a year? _____
- What time of the year does it occur? _____ Spring _____ Summer _____ Fall _____ Winter
- Tell us about other respiratory symptoms you have had in last 4 weeks by marking a (X) in the box on the 0-5 scale:

	0 None	1 Mild	2	3 Moderate	4	5 Severe
Wheezing						
Shortness of breath						
Mucus/Phlegm						

Can you estimate the amount of the phlegm you produce in 24 hours? _____ 24 hours

Do you use an albuterol HFA or a nebulizer? Yes No If yes, how often?

- 3+ times a day
- 1-2 times a day
- 2-3 times a week
- less than once a week

- Tell us about your nasal/sinus symptoms you have had in the last 4 weeks by marking an X in the box on the 0- 5

	0 None	1 Mild	2	3 Moderate	4	5 Severe
Runny nose						
Stuffy nose						
Sneezing						
Itchy/Watery eyes						

- Are your respiratory symptoms worse at certain times of the year? If so, please mark an X in the months it worsens.

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Wheezing												
Shortness of Breath												
Mucus/Phlegm												

How is your sense of smell? Normal Decreased Non-Existent

Does your nose run? Yes No
 What is the nature of discharge? Watery Mucous White Yellow
 If it is clear watery discharge, how much? Little Quite a bit Large Amount
 Does your nose run when you bend over? Yes No
 Any Injury to the head? Yes No If yes, when? _____
 Have you undergone any nasal or sinus surgery? Yes No If yes, when? _____

CHRONIC MEDICAL PROBLEMS: Please list all of your medical conditions, even if controlled with medication

PERSONAL

Education: Grade School ___ grade High School 1 2 3 4 College 1 2 3 4 _____

Marital Status: Single Married/Partner Divorced Separated Widowed

Children: Yes No If yes, how many? _____

Race/Ethnicity: _____ Preferred Language: _____

Occupational History:

Job Title	Dates of Employment	Description	Health Risks/Exposures	Injuries Illnesses

Are you exposed to anything at work that might aggravate your condition? Yes No. Which things? _____

Do your symptoms get worse at work? Yes No

Are your symptoms better on weekends, holidays, or on your days off? _____

Environmental History

What do you do to cool your home?: Central Air Swamp Cooler Open Windows Fans

What do you do to heat your home?: Furnace Fire Place/Wood Burner Radiant Flooring Baseboard heat

Are you aware of any exposure to the following?: Mold Water Damage Candles Air Fresheners

Other exposures of concern? _____

Pets (Please indicate how many?)

<input type="checkbox"/> Dogs # _____	<input type="checkbox"/> Indoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Indoor/Outdoor	<input type="checkbox"/> In Bedroom
<input type="checkbox"/> Cats # _____	<input type="checkbox"/> Indoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Indoor/Outdoor	<input type="checkbox"/> In Bedroom
<input type="checkbox"/> Birds # _____	<input type="checkbox"/> Indoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Indoor/Outdoor	<input type="checkbox"/> In Bedroom
<input type="checkbox"/> Other # _____	<input type="checkbox"/> Indoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Indoor/Outdoor	<input type="checkbox"/> In Bedroom

Previous Allergy Evaluation and Therapy

Have you ever had allergy skin tests? Yes No

Date _____ Physician's Name _____ Results: _____
 (If possible, please provide us with a copy)

Have you ever received allergy injections? Yes No Dates _____

Exercise

Do you exercise regularly? Yes No How often? _____

Fill out the birth history if the patient is younger than 16 years of age.

Birth weight: _____ lbs. _____ oz. Any complications during pregnancy or delivery? _____

Is growth normal? Yes No

Any feeding problems? Yes No

Immunization History (check type of vaccine and most recent administration)

Influenza Vaccine (flu shot) Last given _____

Pneumococcal Vaccine (pneumonia shot) Last given _____

Tetanus & Diphtheria Last given _____

Medications: Prescriptions/OTC/Herbals/Vitamins/Supplements (list all)

No	Medication Name	Dose (mg, mcg, ml, etc.)	By mouth, injection, inhalation, etc.	How Often?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

DRUG ALLERGIES: Please list any ADVERSE REACTIONS to drugs:

Name of Drug	When did it happen?	Symptom(s)

Smoking History:

Patient has never smoked

Patient currently smokes: Cigarettes— _____ pks/day Cigar Pipe Marijuana

Patient previously smoked: Cigarettes Cigar Pipe Marijuana

Age start= _____ Age stop= _____ Average packs/day= _____ Other forms of tobacco: _____

Smoker(s) in home Yes No Who: _____

If your smoking, please discuss with us; we urge you to quit: <https://smokefree.gov/quit-smoking/getting-started/steps-to-manage-quit-day> Also you can call 1-800-QUIT-NOW

Alcohol or Substance Use:

Do you drink alcohol? Yes No If so, how much?: _____ (# per day/week/month)

Any problems with alcohol now or in the past? Yes No

Do you use any illegal drugs? Yes No

Exercise and Nutrition Information:

For information on exercise and nutrition please check this link which provides evidence based medical information;

Please do not hesitate to ask us questions. www.mybestallergist.com Then go to become a new patient and select the links.

HOSPITALIZATIONS & SURGERIES: What surgical procedures have you had? (provide year & details, if possible)

Procedure	Year	Procedure	Year
Sinus Surgery		Heart Surgery (Coronary artery bypass, Valve replacement, pacemaker, etc.)	
Lung Surgery		Other _____	
<input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Adenoidectomy		Other _____	
Thyroid Surgery		Other _____	

Family History

Disease	Yes	No	Relation	Comments
Allergies				
Allergic Rhinitis				
Asthma				
Chronic Obstructive Pulmonary Disease/(COPD)				
Cystic Fibrosis				
Emphysema				
Frequent Pneumonia				
Hay fever				
Pulmonary Fibrosis				
Tuberculosis				
Other :				

Review of Systems: What symptoms have you experienced in the last 6 months?

Ear, nose, mouth and throat

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Ear Pain/Ache						Mouth Sores					
Ear Infection						Nasal Polyps					
Hearing Loss						Post-Nasal Drip					
Hoarseness in voice						Sinus Pain					
Nosebleeds						Throat Tightness					
Enlarged lymph nodes						Sinus Infections					
If so where?											

Lungs and chest symptoms (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Cough productive						Chest Tightness					
What Color? _____						Low Oxygen Levels					
Coughing up blood						Chest X-Ray?	When?				
Frequent "chest colds"						<input type="checkbox"/> Yes <input type="checkbox"/> NO					
						Other _____					

Blood and Lymph Nodes (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Swollen Glands						Easy bleeding					

Heart (provide frequency and severity— mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Can't lie flat						Chest Pain					
Fainting Spells						Where? _____					
Irregular Heartbeat						Heart Murmur					
Swelling of Ankles						Swelling of Legs					

Tell us about the symptoms of GERD you have had in the last 7 days:

Please answer the following questions by circling the number in the corresponding box	0 day	1 day	2-3 days	4-7 days
How often did you have a burning feeling behind your breastbone (heartburn)?	0	1	2	3
How often did you have stomach contents (liquid or food) moving upwards to your throat or mouth (regurgitation)?	0	1	2	3
How often did you have difficulty getting a good night's sleep because of your heartburn and/or regurgitation?	0	1	2	3
How often did you take additional medication for your heartburn and/or regurgitation, other than what the physician told you to take? (such as Tums, Roloids, Maalox?)	0	1	2	3

Genitourinary (provide frequency and severity—mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Excessive Night Urination						Painful Urination					
Frequent urination						Urinary Incontinence					
Difficulty Urinating						Irregular menses (period)					

Muscles and Bones (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Joint Stiffness						Joint Pain					
Muscle Pain						Joint Swelling (which joint?)					

Neurologic (Brain) (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Concentration Problems						Tremor					
Weakness						Memory Problems					
Numbness (Where?)						Seizures					

Fall Risk Assessment

Please answer the following questions		Yes	No
Have you fallen in the past year?			
Do you have difficulty getting around, or with balance?			
Are you afraid of falling?			

Sleep (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?		None	Mild	Mod	Severe	How Often?
Excessive Daytime Sleepiness						Insomnia					
Snoring						Stop Breathing in Sleep					

Psychologic (Mood) (provide frequency and severity-mild/moderate/severe)

	None	Mild	Mod	Severe	How often?
Anxious/Worried					
Mood Swings					
Panic Attacks					

Depression Screening Questions

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Over the past 2 weeks, how often have you been bothered by any of the following problems?				
Little interest or pleasure in doing things.				
Feeling down, depressed, or hopeless				

STOP

HEALTH EDUCATION

DATE:	Yes	No	MA's Initials	Comments
Asthma:				
1. Advair/Dulera/Symbicort/Breo/Anoro Flyer				
2. Two ICS consent form				
3. Singulair Flyer				
4. Hands on use of inhalers				
5. Short course of Prednisone form				
6. Asthma Slides				
7. Recommend Influenza Vaccine				
8. Recommend Pneumococcal Vaccine				
Urticaria:				
1. Explain urticaria and hives are the same				
2. Review urticaria website				
3. Go over multiple antihistamine form				
4. Skin Care				
5. Punch Biopsy Consent				
Allergy				
1. Give copy of skin test				
2. Allergy Injection Program consent				
Anaphylaxis				
1. Epi Pen Training				
2. Anaphylaxis Form				
• Medical ID www.identifyyourself.com (800) 343-5985				
• E-Mail website FAAN www.foodallergy.org				
Sinus				
1. Scope Consent				
Radiology/ Labs				
1. Lab Slip Given (Explain: address, fasting, no appt needed)				
2. Chest X-ray slip given (Explain: address, no appt needed)				
Before Patient Leaves				
1. Explain paperwork twice				
2. Instructions for medication				
3. Note for school				
4. Prescriptions sent to pharmacy/ or written script given				
5. Tell patient if meds are not covered by insurance or are to expensive, ask the patient to call us ASAP. _____				

I will keep my follow-up appointments as advised. If I do not keep my appointments, I can develop poor outcomes. Why?
Depending on my progress, during follow-up visits:

1. Dr. Patel can change my medications, for example, add new ones, decrease the dose, or stop them.
2. Dr. Patel can add more tests to confirm or revise the diagnosis.
3. Dr. Patel can refer me to another doctor.
4. Dr. Patel may have some other ideas.
5. I will come for follow up to discuss the results of the tests; I may suffer poor outcomes if I do not come for follow up to discuss the test results in person. _____ (Int.)

I understand that if I do not keep my follow-up appointments, I take full responsibility for any adverse outcomes which may arise because I failed to keep my follow-up appointments. Continuing care with Dr. Patel requires follow ups. By not keeping follow up appointments I am implying that I do not want to continue care with Dr. Patel. _____ (int.) If I can not keep my follow up appointment I will reschedule it and keep the rescheduled appointment.

Patient Signature

M.A.'s Signature

