Name: _____ **DOB:** _____ **Age:** _____ **Sex: M/F Date:** _____

Companions Name/Relationship: _____ **Pharmacy:** _____

Reason for Visit: ☐Follow-up ☐Scope ☐Flare-up ☐Skin Test **Refills: Y/N** _____

Have you taken Allegra (fexofenadine) Zyrtec (Cetirizine), Claritin (Loratadine), Benadryl (Diphenhydramine), Xyzal (Levocetirizine) **When?** _____

Primary Care Provider: Y/N If yes: Name: _____ **Phone:** _____

Flu Shot? When? _____ **Pneumonia shot?** When? _____ **Diagnosis of Depression? Y/N** Medication? _____

	None	Mild	Mod	Sev
Cough:				
Daytime: AM/PM				
Bedtime:				
In Sleep:				
Triggers:				
Exercise:				
Talking:				
Laughing:				
Wheezing:				
Exercise:				
Talking:				
Laughing:				
Shortness of breath:				
Exercise:				
Talking:				
Laughing:				
Phlegm/Mucous:				
Blood in Sputum:				

	None	Mild	Mod	Sev
Nasal Congestion:				
Sneezing:				
Runny Nose:				
Post Nasal Drip:				
Change in Smell/Taste:				
Nose Bleeds: Y/N	**Last:**			
Itchy/Watery Eyes:				
Rash/Ecz/Hives				
Location:				
Pregnancy: Y/N	**How many Wks:**			
Current Smoker: Y/N				
Former Smoker: Y/N				
How many years:				
Qty Per Day:				
Note for Work/School: Y/N				

How often do you use Rescue Inhaler (Albuterol)? /Day /Wk /Month

Review of Symptoms

Heartburn:	Yes	No
Swelling of Legs	Yes	No
Throat Swelling	Yes	No
Tongue Swelling	Yes	No
Irregular Heartbeat	Yes	No
Diabetes	Yes	No
Sleep Apnea	Yes	No
Voice changes	Yes	No
Fever	Yes	No
Chills	Yes	No
Hx Blood Clots	Yes	No
Where:		
Other Medical Problems	Yes	No
What? _____		
Fall Risk ?	Yes	No

- _____**STOP HERE**_____**STOP HERE**_____**STOP HERE**_____

Last Visit: _____ Room # _____ **ACT Score:** 1. 2. 3. 4. 5. 6. 7. =

Labs work/Biopsy? Y/N Date: _____ **X-Ray/CT Scan/Other? Y/N Date:** _____

Skin Test I: _____Allergy Inj. Y/N_____Skin Test F: _____Alpha-1 Lvl: _____ Nasal Scope: _____

IgG Level: _____ Stress Test: _____Chest X-ray:_____ CT Scan: _____ Video?_____

Follow Up: _____ ☐ Can Leave