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

Companions Name/Relationship: _____

Reason for the follow up: _____ **Refills: Y/N**_____

Pharmacy:_____

Primary Care Provider:_____**Phone:**_____

	None	Mild	Mod	Sev		None	Mild	Mod	Sev	**Review of Symptoms**		
Cough:					Nasal Congestion:					Fever	Yes	No
Daytime: AM/PM					Sneezing:					Chills	Yes	No
Bedtime:					Runny Nose:					Heartburn	Yes	No
In Sleep:					Post Nasal Drip:					Headache	Yes	No
Triggers:					Change in Smell/Taste:					Ear Pain	Yes	No
Exercise:					Nose Bleeds:					Irregular Heartbeat	Yes	No
Talking:					Itchy Eyes:					Diabetes	Yes	No
Laughing:					Watery Eyes:					Voice changes	Yes	No
Wheezing:					Eczema/Hives					Fall Risk	Yes	No
Exercise:					Sleep Apnea Yes No					Depression	Yes	No
Talking:					Swelling of legs Yes No							
Laughing:					Lip/Tongue/Throat: Yes No					Any other comments:		
Shortness of breath:					Blood Clots in the lungs: Yes No							
Exercise:					Current Smoker: Yes No							
Talking:					Former Smoker: Yes No							
Laughing:					How many years: Qty per day:							
Phlegm/Mucous:					Pregnancy: Yes No How many Wks.:							
Blood in Sputum:					Do you need a note for Work/School: Yes No							
How often do you use Rescue Inhaler (Albuterol)? /Day /Wk /Month												

Current Medical Problems:

Name Of Medical Problem:	When diagnosed:	Active or Inactive:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications, first list medications prescribed by Dr. Patel, then list all other medications:

Name of Medication:	How Many Pills/Puffs:	How often:	When was it started:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ D.O.B. _____ Date:_____

Insurance: _____ Account Balance: _____

Last Visit: _____ Pharmacy: _____ Refills Y/N: _____

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

Skin Test Inhalants: _____ Skin Test Foods: _____ Alpha-1 Lvl: _____ Alpha-1 Pheno: _____

Nasal Scope: _____ IgG Level: _____ Stress Test: _____Chest X-ray: _____

CT Scan: _____Video Y/N _____ FEV 1: _____

Follow up: _____ ☐ Can Leave