Kentuckiana Allergy Follow Up Visit

Name____DOB_______________Date__________________

Pharmacy Name & Phone Number: ____

Email Address: ____

SINCE YOUR LAST VISIT (please circle all that apply)

Currently smoking: Y / N   Past Smoker, quit (year) ______   Smoked for _______ yrs

On Allergy Shots: Y / N , Build / Maintenance , How often _____ , Helpful? Y / N / Maybe , Reactions? Y / N

Current Pets at Home: # of Cats______ # of Dogs______ Other Animals___________________

Overall My Allergies Are: Well Controlled Not Controlled Better Worse Same

Constitutional: Significant (20 lbs) Weight loss or Weight gain Fever Malaise Fatigue

Neurologic: Headaches Migraines Vertigo Dizziness

Eyes: Itching Watery Red Mucus Vision Changes Puffiness

Ears: Ringing Fullness Hearing Loss Ear Tubes

Nose: Congestion Runny Nose Sneezing Itching Sinus Pain Loss of Smell

Mouth: Sore Throat Post Nasal Drip Swelling Itching Throat Clearing Mouth Breathing Snoring

Heart: Chest Pain Irregular Heart Beat Cardiovascular Disease Palpitations

Lungs: Congestion Chest Tightness Wheezing Cough Shortness of Breath Problems Exercising

Gastric: Vomiting Diarrhea Nausea Reflux Cramping Loose Stools

Skin: Itching Rash Hives Swelling Eczema

Hematologic: Anemia Easy Bruising Bleeding Skin Pallor

Immunologic: # of Infections since last visit=> Sinus # , Ear # , Lungs # , GI # , Skin #

Endocrine: Excessive Thirst / Hunger Heat/Cold Intolerance Fast Heart Rate Thyroid Problems

Other Current Problems: ____

SINCE YOUR LAST VISIT (dates if known)

Surgeries: ____

Hospitalizations: ____

ER Visits: ____

Oral Steroids Courses: ___________________________Antibiotics: __________________________

X-Rays/CT Scans: ____

New Job:(explain) ______________________New Home/School/Daycare:______________________

If you use any type of LUNG INHALER, please fill out the following:

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?
   1 All of the time 2 Most of the time 3 Some of the time 4 A little of the time 5 None of the time ________
2. During the past 4 weeks, how often have you had shortness of breath?
   1 More than once per day 2 Once per day 3 3 to 6 times per week 4 Once / twice per week 5 Not at all ________
3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?
   1 4 or more nights per week 2 2 / 3 nights per week 3 Once per week 4 Once or twice 5 Not at all ________
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol)?
   1 3 or more times per day 2 1 to 2 times per day 3 2 or 3 times per week 4 Once per week or less 5 Not at all ________
5. How would you rate your asthma control during the past 4 weeks?
   1 Not controlled at all 2 Poorly controlled 3 Somewhat controlled 4 Well controlled 5 Completed controlled _______

Total ACT Score ______

Current Family Doctor:_____________________________

Other Doctors that care for you:____