GRAND RAPIDS ALLERGY 970 Parchment Dr. S.E. Grand Rapids, MI 49546 P.616.949.4840 F. 616-949-3531 www.grandrapidsallergy.com

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

Form completed by (circle): Patient Spouse Parent/Guardian Primary care provider? _____ City? _____

Reason for visit? (circle) Annual visit Rx Renewal New Problem - Began _____ Describe: _____

ON ALLERGY SHOTS / DROPS / TABS? ☐ No ☐ Yes How long? _____ Satisfaction (circle): Excellent Good Fair Poor

Estimated Improvement (0-100%): _____ Office where shots are received? _____ City? _____

Any reactions or concerns? _____

IF YOU HAVE ASTHMA - Have you been hospitalized or in the ER for asthma since your last visit? ☐ Yes ☐ No

Can you be physically active without cough/wheeze, or shortness of breath? ☐ Yes ☐ No Prednisone since last visit? ☐ Yes ☐ No

ASTHMA CONTROL TEST **Score**

1. In the past 4 weeks, how much time did your symptoms keep you from getting as much work done at work, school, or home?

(1) All the time (2) Most of the time (3) Some of the time (4) A little of the time (5) Never ☐

2. During the past 4 weeks, how often have you had shortness of breath?

(1) More than once/day (2) Once per day (3) 3-6 times a week (4) Once or twice a week (5) Not at all ☐

3. During the past 4 weeks, how often did these symptoms wake you up at night or earlier than usual in the morning?

(1) 4 or more nights per week (2) 2-3 nights/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/day (2) 1-2 times/day (3) 2-3 times/week (4) Once per week (5) Not at all ☐

5. How would you rate your asthma symptom control during the past 4 weeks?

(1) Not controlled (2) Poor control (3) Somewhat controlled (4) Well-controlled (5) Complete Control ☐

PERSONAL HISTORY

Occupation? _____ Smoker? ☐ No ☐ Yes How long? _____ Packs/day? _____ Year stopped? _____ Other smokers in home? _____

Medication allergies? (list) _____ Describe reaction: _____

Medications for asthma/allergy	Dose & Frequency	Other medications, daily or as needed	Dose & Frequency

REVIEW OF SYSTEMS (check if present in past 1-2 weeks)

CONSTITUTIONAL
- ☐ Fever
- ☐ Sweats
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Headache
- ☐ Negative

Other: _____

RESPIRATORY
- ☐ Cough
- ☐ Wheeze
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Negative

Other: _____

EARS
- ☐ Plugged ears
- ☐ Multiple infections
- ☐ Decreased hearing
- ☐ Negative

Other: _____

GI
- ☐ Vomiting
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Bloating
- ☐ Poor appetite
- ☐ Constipation
- ☐ Gas
- ☐ Negative

Other: _____

NOSE
- ☐ Plugged nose
- ☐ Multiple infections
- ☐ Congested
- ☐ Sneezing
- ☐ Runny nose
- ☐ Nasal polyps
- ☐ Nose bleeds
- ☐ Decreased smell
- ☐ Negative

Other: _____

ALLERGY
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Gland swelling
- ☐ Negative

Other: _____

THROAT
- ☐ Congested
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Negative

Other: _____

SKIN
- ☐ Rash
- ☐ Hives
- ☐ Dryness
- ☐ Itching
- ☐ Eczema
- ☐ Negative

Other: _____

EYES
- ☐ Itchy
- ☐ Watery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Negative

Other: _____

ENDOCRINE
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Diabetes
- ☐ Negative

Other: _____

CARDIOVASCULAR
- ☐ Chest tightness
- ☐ High blood pressure
- ☐ Negative

Other: _____

PSYCH
- ☐ Anxiety
- ☐ Sleep disturbance
- ☐ Lack of energy
- ☐ Negative

Other: _____

HOME ENVIRONMENT (circle)

Dogs # _____ Cats # _____ Other _____

Inside Outside Bathed

How often are they bathed? _____

	YES	NO
Pets sleep in bedroom?	☐	☐
Pets sleep in bed?	☐	☐
Dust mite encasings	☐	☐
Hot water washings	☐	☐
Bedroom carpeted	☐	☐
HEPA filter in home	☐	☐
HEPA filter in bedroom	☐	☐
Air-conditioning	☐	☐
Dehumidifer	☐	☐

Other _____

PAST HISTORY: In the past 5 years have you had (circle)

Major illness Surgery Food allergy Drug Allergy Bee Sting allergy None Other _____

Family history of allergy? ☐ No ☐ Yes

% of days this year you've had allergy symptoms (0-100%) _____ # of missed work or school days per year _____ # of antibiotics this year _____

Provider: _____

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PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

Please circle the number that describes the skin on each part of your or your child's body. Please circle any and all that apply.

	Clear	Dry	Scaly	Redness	Cracks/Openings	Oozing
Head	0	1	2	3	4	5
Neck	0	1	2	3	4	5
Trunk	0	1	2	3	4	5
Arms	0	1	2	3	4	5
Hands	0	1	2	3	4	5
Legs	0	1	2	3	4	5
Feet	0	1	2	3	4	5

TOTAL: ☐ **/ 35**

Please circle the number that describes the intensity of itching associated with your eczema. Please circle only one.

	None	A little bit bothered	Somewhat bothered	Quite bothered	Very Bothered	Extremely bothered/ sleep loss
Head	0	1	2	3	4	5
Neck	0	1	2	3	4	5
Trunk	0	1	2	3	4	5
Arms	0	1	2	3	4	5
Hands	0	1	2	3	4	5
Legs	0	1	2	3	4	5
Feet	0	1	2	3	4	5

TOTAL: ☐ **/ 35**

OVERALL SCORE: ☐ **/ 70**

STAFF USE ONLY

Height: _____(%_____) Weight: _____(%_____) BP (sitting)_____ Pulse_____ T_____ RR_____ RN/MA _____

CC / HPI / Annual Progress _____

PRE PFT

	Value	% Pred	Pred
FVC	☐	☐	☐
FEV1	☐	☐	☐
FEV1 / FVC%	☐	☐	☐
FEF 25-75	☐	☐	☐

POST PFT

	Value	% Change
FVC	☐	☐
FEV1	☐	☐
FEV1 / FVC%	☐	☐
FEF 25-75	☐	☐

Provider: _____