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

Companion Name/Relationship: _____

Reason for the follow up: _____

_____

Refill: Y ☐ **N** ☐ _____ **Pharmacy:** _____

Have you taken any Antihistamines (Xyzal, Zyrtec, Allegra, Claritin, Benadryl)? Y ☐ **N** ☐ **When?** _____

Primary Care Physician: _____ **Phone #:** _____

	None	Mild	Mod	Sev		None	Mild	Mod	Sev		Yes	No
Cough	☐	☐	☐	☐	**Phlegm/Mucous**	☐	☐	☐	☐	**Sleep Apnea**	☐	☐
AM/PM	☐	☐	☐	☐	**Blood in Sputum**	☐	☐	☐	☐	**Swelling of legs**	☐	☐
Bedtime	☐	☐	☐	☐	**Nasal Congestion**	☐	☐	☐	☐	**Lip/Tongue/Throat**	☐	☐
In Sleep	☐	☐	☐	☐	**Runny Nose**	☐	☐	☐	☐	**Blood Clots in the Lungs**	☐	☐
Triggers	☐	☐	☐	☐	**Post Nasal Drip**	☐	☐	☐	☐	**Fever**	☐	☐
Exercise	☐	☐	☐	☐	**Nose Bleeds**	☐	☐	☐	☐	**Chills**	☐	☐
Talking	☐	☐	☐	☐	**Itchy Eyes**	☐	☐	☐	☐	**Heartburn**	☐	☐
Laughing	☐	☐	☐	☐	**Watery Eyes**	☐	☐	☐	☐	**Headache**	☐	☐
Wheezing	☐	☐	☐	☐	**Eczema/Hives**	☐	☐	☐	☐	**Ear Pain**	☐	☐
Exercise	☐	☐	☐	☐		☐ Never		☐ Former		**Irregular Heartbeat**	☐	☐
Talking	☐	☐	☐	☐	**Smoking Status**	☐ Current		Pack/day: _		**Diabetes**	☐	☐
Laughing	☐	☐	☐	☐	**Do you need a note for school/work? Y** ☐ **N** ☐					**Voice Changes**	☐	☐
Shortness of Breath	☐	☐	☐	☐						**Fall Risk**	☐	☐
Exercise	☐	☐	☐	☐						**Depression**	☐	☐
Talking	☐	☐	☐	☐						**Pregnant**	☐	☐
Laughing	☐	☐	☐	☐	**How often do you use Rescue Inhaler (Albuterol)?** _____/day _____/week ____							

Please list all current medications, medications prescribed by Dr. Patel first, then list all other medications: *If you take more medication, please add it on a separate paper.*

Name of Medication:	How many pills/puffs?	How often?	When was it started?

CURRENT MEDICAL PROBLEMS:

Name of Medical Problem:	When was it Diagnosed:	Name of Medical Problem:	When was it Diagnosed

Other comments and questions for Dr. Patel:

Patient/Guardian Signature: _____

Typing your name is equivalent to your handwritten signature

By typing my signature and sending it to via the internet, I acknowledge that I have read and understand all information provided in this form; that I intend Ashok PC to rely upon it; that I intend to be bound thereby; ant that I understand and agree that my electronic signature is equivalent of a manual written signature.

Dear patients, please do not write in the spaces below.

For Office Use Only

Name: _____ DOB: _____ Date: _____
Insurance(s): _____ Account Balance: _____
Last Visit: _____ Refill: Y ☐ N ☐ _____Pharmacy: _____
Lab Work/Biopsy? Y ☐ N ☐ Date:_____Alpha1 level:_____ Alpha 1 Pheno _____ Ig G level: _____
X-Ray/CT Scan/Others? Y ☐ N ☐ Date:_____ Chest X-Ray: _____ CT Scan: _____
Skin Test (Inhalants): _____Skin Test (Food): _____ Nasal Scope: _____FEV1: _____Stress Test: _____

What medications is the patient taking?

Name of Medication:	How many pills/puffs?	How often?	When was it started?

Patient's concerns and questions:

_____
_____
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Plan:

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Address during Telemedicine _____
_____

I will make arrangement for appropriate vaccinations

Follow up: _____ ☐ Can Leave

Signature:_____