Name:___________________________**DOB:** _______________ **Age:** ______ **Sex: M** ☐ **F** ☐ **Date:** ____________________

Companions Name/Relationship: ____

Reason for the follow up: ____

____

Refills: Y / N _______________________________ **Pharmacy:**____

Have you taken any Antihistamines (Xyzal, Zyrtec, Allegra, Claritin, Benadryl)? Yes ☐ **No** ☐ **When?**__________________________

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/Guardian Signature_________________________________

Typing your name is equivalent to your handwritten signature

By typing my signature and sending it 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; and that I understand and agree that my electronic signature is the equivalent of a manual written signature.

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