

HIVES/SWELLING FOLLOW UP

PATIENT: _____

DATE: _____

OFFICE: UNIVERISTY ORANGE PARK MANDARIN

DOB: _____ AGE: _____

DATE OF LAST OFFICE VISIT: _____

REASON FOR VISIT: Please indicate follow-up/problem.

Did you bring your diet or diary? YES NO

What are you eating?

Did you stop NSAID's?

Did you stop other meds? NO
YES.....What? _____

Did you stop all Additives? YES NO

Did you reduce the naturally occurring salicylites (example – tomatoes) in your diet?

Did you reduce the herbs in your diet?

Have you had any new triggers? NO
YES _____

Before diet Average # _____ Wks

On diet Average # _____ Wks

Are you better on the diet? YES NO

Does it make a difference? YES NO

How much? 10 20 30 40 50 60 70 80 90 100%

HOME ENVIRONMENT:

Have you moved since your last visit? _____

Have you made any new changes at home since last visit? _____

Any changes at work? _____

PAST HISTORY:

New Hospitalization or ER visit? _____

New Drug Allergies? _____

New Food Allergies? _____

New Insect Allergies? _____

New Latex Allergies? _____

FAMILY HISTORY:

Anyone sick at home? Y N

Who _____ What _____ When _____

Anyone passed away recently since last seen? Y N

SOCIAL HISTORY:

Where are you working? _____

What is your occupation? _____

Have you retired? N Y

Do you have any new hobbies? _____

REVIEW OF SYSTEMS: *Please circle and then write full details below*

Epilepsy

Headaches

Migraines

Double Vision

Blindness

Trouble Hearing

Earache

Trouble Swallowing

Dental Problems

Sore Throat

Chest Pain

Heart Problems

Stomach/Bowel Problems

Diarrhea/Constipation?

Black or tarry stool

Urine Problems

Joint Problems

Skin Rash

Appetite Good

Weight Up? _____

Weight Down? _____

Are you dieting? N Y

Nausea

Vomiting

Date of Last Physical _____

Results: _____

Date of Last Labs _____

Results _____

Date of Last Mammogram

Results _____

Fluid Intake & Urination

Good N Y

Any new medical problems or

Conditions? N Y

Details

PHYSICAL