

NASAL/CHEST FOLLOW UP

PATIENT: _____

DATE: _____

OFFICE: UNIVERISTY ORANGE PARK MANDARIN

DATE OF BIRTH: _____ AGE: _____

OFFICE STAFF TO COMPLETE

Date of last office visit _____

Shot Patient? Y N

Is shot card attached Y N

Today's date on shot card Y N

Expiry Date of antigen _____

**staff to complete template info on EMR

SHOT PATIENTS TO COMPLETE

Interval between shots? _____

Can you tell if you miss a shot? Y N

What percentage are shots helping you? 10% 30% 50% 80% 90% Other__

Have you had any reaction to shots? N Y if yes what happened? _____

How long did it last? _____

Did you tell the nurse? Y N

Was the reaction noted on your shot card? Y N

Do you wait 30 minutes after shots? Y N

ALL PATIENTS TO COMPLETE

Please indicate reason for your visit today.

_____ Well check up

_____ Trouble: **Please circle**

Asthma Cough Allergy Fever URI Earache/Earplug Sore Throat

Have you had an elevation in your temperature in the past 24 hours? N Y

If yes - what was it? _____ When did it begin? _____ Did you take anything for

it? If yes - what? _____. When was the last dose? _____

Details regarding reason for visit: _____

***** (MD use only – Current Allergy/Asthma Medication)*****

Can you tell if you miss your allergy or Asthma medications? Y N

Which One? _____

HEAD PROBLEMS: Y N

Sinus Headache? Y N How often? _____ Where? **Please circle**
Forehead Temples Cheeks Back of Head Forehead/Cheeks Behind Rt/Lt eye

Migraine Headache? Y N Where is it? _____ How often? _____

Other Headache? Y N Where is it? _____ How often? _____

What makes headache: BETTER _____ WORSE _____

Sinus Headache?

Migraine Headache?

Other?

NOSE OR SINUS PROBLEMS: Y N Please circle

Headache Runny Nose Discolored Mucus Itchy Nose Sneezing Stuffiness

Drainage (post nasal drip) Color of Drainage _____

How often? _____

What makes sinus problems BETTER _____ WORSE _____

EYE PROBLEMS: Y N Please circle

Burn Tear Itch Other

Do you currently use any eye drops? If yes please indicate _____

CHEST PROBLEMS: Y N Please circle

Wheezing Shortness of Breath Tightness Dry cough Productive cough

PHLEGM how much? _____ (over a 24 hr period) _____ tsp _____ cup Color _____

Phlegm drainage from: Nose chest Don't know.

Are you having any ASTHMA symptoms at night? N Y if yes how many nights this past week? _____

What makes ASTHMA/CHEST COUGH

BETTER? _____

What makes ASTHMA/CHEST COUGH

WORSE? _____

Do you feel secure in your ability to control your asthma attacks? (or child's) _____

Do you own a working Peak Flow Meter? Y N Average Peak Flow? _____

Date and Time of last Peak Flow _____ Date _____ Time _____

HOME ENVIRONMENT

Have you moved since your last office visit? N Y

If yes, how old is house, apt? _____

Is new location better for your allergies? N Y

Any new changes at home? _____

*Do you have any carpet in your house? If yes, please indicate where

*Have your encased your mattress or pillow? _____

Do you have any pets? If yes, please indicate: _____ how many _____ type _____ indoor _____ outdoor

Are you exposed to: (**please circle**) Feather Comforters Wool Blankets Feather Pillows

Do you have any special concerns about your house? (example – dusty, moldy, etc) _____

*Type of furniture in home: Vinyl Leather Cloth (please circle)

*Do you wash in hot water? (130-140 degrees F)

Have you used Acaroson to kill mites? YES NO (please circle)

WORK ENVIRONMENT

Have you changed your occupation? Yes _____ No

Any new changes in your work environment? Yes _____ No

PAST HISTORY

Have you been in the hospital/ER since your last office visit? N Y

If yes please indicate – when, where and for

what _____

Any changes in the following: Please circle

New Drug Allergy New Food Allergy New Insect Allergy New Latex Allergy

If yes, please provide

details: _____

Do you currently smoke? Y N. Did you ever smoke? Y N. If yes, how long ago did you quit? _____

Are you around someone who smokes? Y N ? If yes, what percentage of time are you around them ? _____%.

What antibiotic can you take for sinusitis or bronchitis if you are sick? _____

FAMILY HISTORY:

Anyone sick at home? Y N

Who _____ With what _____ When _____

Anyone passed away recently since you were 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

Chest Pain

Nausea

Headaches

Heart Problems

Vomiting

Migraines

Stomach/Bowel Problem

Double Vision

Black or tarry stool

Diarrhea/Constipation

Blindness

Urine Problems

Date of Last Labs_____

Trouble Hearing

Joint Problems

Results_____

Earache

Skin Rash

Date of Last Mammogram

Trouble Swallowing

Thyroid Problem

Results_____

Dental Problems

Sore Throat

Fluid Intake & Urination

Appetite Good

Good Y N

Are you dieting? Y N

Weight Up_____

Weight Down_____

Date of last physical_____Results_____

Do you have any other new medical Problems or conditions? Y N

Details_____

