HIVES/SWELLING FOLLOW UP

PATIENT: _____
DATE: _____
OFFICE: ST. JOHNS BLUFF 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 salicylates (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