FOLLOW UP NASAL/CHEST

PATIENT NAME: _____
DATE: _____
OFFICE: ST. JOHNS BLUFF 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
Expiration Date of antigen_____

SHOT PATIENTS TO COMPLETE

Interval between shots? _____
Can you tell if you miss a shot? Y N
What percentage are shots helping you? 10% 20% 30% 40% 50% 60% 70% 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
****staff to complete template in EMR****

XOLAIR PATIENTS TO COMPLETE

Interval between shots? _____
Can you tell if you miss a shot? Y N
What percentage are shots helping you? 10% 20% 30% 40% 50% 60% 70% 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
****staff to complete template in EMR****

ALL PATIENTS TO COMPLETE

Please indicate reason for your visit today.
_____Well check up
_____Trouble: **Please circle all that apply**
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:_____
_____
_____
_____
_____

HEAD PROBLEMS: Y N
Sinus Headache? Y N How often?_____
Where are they located? **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:
Sinus Headache? BETTER _____WORSE_____
Migraine Headache? BETTER _____WORSE_____
Other? BETTER _____WORSE_____

NOSE OR SINUS PROBLEMS: Y N **Please circle all that apply**
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 all that apply**
Burn Tear Itch Other
Do you currently use any eye drops? If yes please indicate _____

CHEST PROBLEMS: Y N **Please circle all that apply**
Wheezing Shortness of Breath Tightness Dry cough Productive cough
PHLEGM how much? (Over a 24 hr period) _____tsp _____tbsp _____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) Y N
Do you own a working Peak Flow Meter? Y N Average Peak Flow? _____
Date and Time of last Peak Flow _____Date_____Time

Can you tell if you miss your Allergy or Asthma medication(s)? N Y
Which One(s)? _____
_____

HOME ENVIRONMENT
Have you moved since your last office visit? N Y
If yes, how old is house, apt? _____
Is the 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? Y N

Do you have any pets? N Y 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? N Y If so what: (example – dusty, moldy,etc)
_____
*****Type of furniture in home: Vinyl Leather Cloth **(please circle)**
*****Do you wash in hot water? (Building Code is usually up to 120 degrees F may be scolding but to kill dust mites it has to be 130-140 degrees F) YES NO **(please circle)**
Have you used Acarosan 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? N Y 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? N Y
Who_____ With what_____ When_____
Anyone passed away recently since you were last seen? Y N

SOCIAL HISTORY:

Do you work? N Y If yes 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	Diarrhea/Constipation
Double Vision	Black or tarry stool	
Blindness	Urine Problems	
Trouble Hearing	Joint Problems	
Earache	Skin Rash	
Trouble Swallowing	Thyroid Problem	
Dental Problems	Sore Throat	

Urination Good Y N
Fluid Intake Good Y N
Appetite Good Y N
Are you dieting? Y N Weight Up_____ Weight Down_____

Date of Last Mammogram _____ Results _____
Date of last labs _____ Results _____
Date of last physical _____ Results_____
Last Bone Density Finding _____ Results _____
Last Eye Exam Date _____ Results _____
Date of last Vitamin D workup _____ Results _____

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

Details_____
_____
_____
_____
_____
_____
_____.