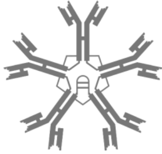

Exton Allergy & Asthma Associates

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FOLLOW-UP PATIENT QUESTIONNAIRE

Please fill out this form and identify health concerns that you have had ***since your last visit*** **Date:** ___________________

Name: ________________________________ **Date of birth:** ____________ **Age:** _______ **Gender:** _____

1. What is the main objective of your visit today? ☐ Routine follow-up ☐ Acute worsening of condition ☐ Symptoms not controlled with treatment ☐ New condition ☐ Medication review/refill ☐ Other

   Please elaborate ____

2. Do you have Asthma? ☐ Yes ☐ No

If you have asthma please also complete the age-appropriate ***Asthma Control Test (ACT)*** *form.* ***If you do not have asthma skip to #3.***

a. How has the control of your symptoms been: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

b. How often do you wake in the middle of the night because of your asthma symptoms of cough, wheezing, shortness of breath or difficulty breathing?

   ☐ More than 1x/day ☐ 1x/day ☐ 2-3x/week ☐ 1x/week ☐ 2-3x/month ☐ Less than 1x/month

c. How often do you use your rescue inhaler (Albuterol, Proventil, Ventolin, ProAir, Xopenex, Maxair)?

   ☐ More than 1x/day ☐ 1x/day ☐ 2-3x/week ☐ 1x/week ☐ 2-3x/month ☐ Less than 1x/month

d. Have you been to the emergency room or hospitalized for asthma since your last visit? ☐ Yes ☐ No

3. Do you have nose/sinus Symptoms? ☐ Yes ☐ No

a. How has the control of your symptoms been? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

b. Which symptoms? ☐ Discharge ☐ Stuffiness ☐ Itching ☐ Sneezing ☐ Postnasal drip ☐ Sinus pressure

4. Do you have a skin rash? ☐ Yes ☐ No What type? ☐ Eczema ☐ Hives ☐ Angioedema ☐ Other

   Please elaborate ____

   How have your skin symptoms been? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

5. Do symptoms of the above conditions generally interfere with your everyday life style? ☐ Yes ☐ No

6. What have you done to decrease your exposure to what you are allergic to? ☐ Keep pets out of bedroom

   ☐ Dust mite covers ☐ Wash bedding in hot water weekly ☐ Control humidity ☐ Other: _______________

7. Do you receive allergy shots (allergen immunotherapy)? ☐ Yes ☐ No If yes, how often?

   ☐ 2x/week ☐ 1x/week ☐ Every 2 weeks ☐ Every 3 weeks ☐ Monthly ☐ Variable (due to side effects)

a. Have you had any adverse reactions to your shots? ☐ Yes ☐ No

   If yes, what happened: ____

8. What medications are you taking? Please list and indicate if you need a new prescription (NP)

NP	Name	Dose	How often	NP	Name	Dose	How often

9. Have you had any adverse reactions to medication since your last visit? ☐ Yes ☐ No

   If yes, what happened: ____

10. Do you have any drug allergies? ☐ No ☐ Yes
    If yes, please list: ____

11. Do you see a new primary care doctor? ☐ Yes ☐ No Do you see any other doctor? ☐ Yes ☐ No
    Name (specialty) of doctor(s): ____

12. Have you had any new medical problems or surgeries since your last visit? ☐ Yes ☐ No
    Please elaborate: ____

13. Is there anything else about your Health that your physician should know? ____________________________
    ____

14. Date of last flu shot: _____________ Any adverse reactions? ☐ No ☐ Yes Which? ______________

15. Have you had a pneumonia/pneumococcal shot? ☐ No ☐ Yes When: ______________________

16. What is your current occupation? ________________________
    Are you exposed to any allergens or potentially hazardous substances at work? ☐ No ☐ Yes
    Please specify: ____

17. Besides yourself, who else lives in your household? ____

18. Do you have any pets? ☐ Yes ☐ No If yes, what kind and how many? ____________________________
    Do your symptoms worsen on exposure or after contact with your pets? ☐ Yes ☐ No

19. Do you smoke? ☐ Yes ☐ No If yes, how much? ___________ Do you want to quit? ☐ Yes ☐ No
    a. Have you smoked in the past? ☐ Yes ☐ No If yes, when did you quit? ____________________
    b. Does anyone in your house smoke? ☐ Yes ☐ No If yes, who? ________________________________

20. Do you drink alcohol? ☐ Yes ☐ No

21. Has there been any change in your life since your last visit that could affect your health? (Job, pets, smoke, etc.)
    ____

22. Please indicate symptoms that you have had in each system **since your last visit**.

GENERAL: ☐ Fever ☐ Chills ☐ Night sweats ☐ Unintentional weight loss ☐ Excessive weight gain

EARS: ☐ Ear pain ☐ Ear pressure ☐ Ear discharge ☐ Hearing loss ☐ Ringing in ear

EYES: ☐ Glaucoma ☐ Vision change ☐ Itching ☐ Irritation ☐ Redness ☐ Watery eyes ☐ Dry eyes

NOSE/SINUS: ☐ Discharge ☐ Dryness ☐ Irritation ☐ Bleeding ☐ Sinus pressure

MOUTH/THROAT: ☐ Ulcers ☐ Sore throat ☐ Itching ☐ Gum disease ☐ Bad breath ☐ Sour/bitter taste

HEART: ☐ Chest pain ☐ Abnormal heart beats ☐ Exercise intolerance ☐ Swelling in feet and ankles

LUNGS: ☐ Shortness of breath ☐ Wheeze ☐ Cough ☐ Excessive mucus/phlegm

ABDOMEN: ☐ Belly pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Heart burn ☐ Water brash

GENITOURINARY: ☐ Frequency of urine ☐ Weak urine stream ☐ Enlarge prostate ☐ Irregular periods

SKIN: ☐ Rash ☐ Atopic dermatitis/eczema ☐ Itching ☐ Dry skin ☐ Nail problem

MUSCULOSKELATAL: ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Weakness

NEUROLOGIC: ☐ Headache ☐ Dizziness ☐ Loss of function ☐ Loss of sensation ☐ Fatigue

MENTAL STATUS: ☐ Poor memory ☐ Confusion ☐ Depression ☐ Anxiety ☐ Insomnia

SLEEP: ☐ Poor quality ☐ Snoring ☐ Lack of refreshing sleep ☐ Daytime sleepiness ☐ Falling asleep involuntarily

Form filled out by: ______________________________ **Relationship to the patient:**___________________________