NORTHEAST
Allergy, Asthma & Immunology

Name ______________________ DOB ______________________

What are the health issues that we follow you for?	How have they been since the last visit? (better/worse/same....)	Do you need better control of this problem?

Patient Demographics

Please add the medicines used since the last visit and the actual amount used

Every day medicines:

Name	Strength	Times a Day	Times a Week	Helps?

Every day medicines:

Name	Strength	Times a Day	Times a Week	Helps?

Any changes in your health? ______________________

Any changes in your environment/home? ______________________

Please check if the patient is experiencing any of the below:

General

- [ ] Fevers
- [ ] Chills
- [ ] Night Sweats
- [ ] Weight Loss
- [ ] Felling Tired a Lot of Time

Head, Ears, Eyes, Nose, Throat

- [ ] Vision Changes
- [ ] Hearing Changes
- [ ] Sore Throat
- [ ] Snoring
- [ ] Congestion
- [ ] Runny Nose

Respiratory

- [ ] Difficulty Breathing
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Heart disease
- [ ] Coronary artery disease
- [ ] None

Gastrointestinal

- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Heart Burn

Genitourinary

- [ ] Pain With Urination
- [ ] Blood in Urine
- [ ] Increased Frequency of Urination

Hematological

- [ ] Easy Bruising
- [ ] Easy Bleeding

Skin

- [ ] Rashes
- [ ] Itching

Musculoskeletal

- [ ] Muscle Pain
- [ ] Joint Pain
- [ ] Joint Swelling

Neurological

- [ ] Seizures
- [ ] Headaches

Endocrine

- [ ] Get Really Hot Easily
- [ ] Get Really Cold Easily

Psychiatric

- [ ] Anxiety
- [ ] Depression
- [ ] Not Sleeping Well
- [ ] Feeling Very Stressed

Cardiovascular

- [ ] Chest Pain
- [ ] Heart Skipping a Beat