Allergy and Asthma Clinic of Central Texas

Patient Name: _____ **Today's Date**: ____/____ /_____
Last First MI **Date of Birth**: ____/____ /_____
MM DD YYYY

Patient email: _____

Chief Complaint: (*BRIEFLY* describe the reason for your visit and what you hope to accomplish today)

_____
_____
_____

Review of Systems: (Please check any symptoms you currently have)

General:	[ ] None
	Fatigue
	Weight loss
	Weight Gain
	Fever

Eyes:	[ ] None
	Redness
	Itching
	Tearing
	Crusting of lids
	Pain

Ears:	[ ] None		
	Congestion		Ringing
	Itching		Vertigo
	Pain		Popping
	Discharge		
	Tubes		

Nose:	[ ] None
	Itching
	Sneezing
	Congestion
	Drainage [ ] clear [ ] white [ ] yellow [ ] green
	Sinus pressure/pain
	Decreased or loss of sense of smell

Mouth:	[ ] None
	Itching of lips/tongue
	Swelling of lips/tongue
	White patches on tongue/soft palate
	Mouth breathing
	Dry mouth
	Bad breath

Throat:	[ ] None
	Itching
	Throat clearing
	Hoarseness
	Difficulty swallowing
	Post nasal drainage
	Sore Throat

Lungs:	[ ] None
	Chest tightness/pressure
	Shortness of breath
	Wheezing
	Coughing [ ] productive [ ] nonproductive
	Exercise-induced symptoms

Heart:	[ ] None
	Chest pressure
	Radiation to arms/neck/jaw
	Rapid heart rate
	High blood pressure

Gastrointestinal:	[ ] None
	Nausea
	Vomiting
	Diarrhea
	Constipation
	Bloating
	Crampy abdominal pain

Genitourinary:	[ ] None
	Urgency
	Frequency
	Painful urination
	Blood in urine

Musculoskeletal:	[ ] None
	Arthritis
	Weakness
	Leg swelling
	Leg cramps

Skin:	[ ] None
	Itching
	Rash
	Eczema
	Hives
	Swelling

Neurological:	[ ] None
	Headaches
	Numbness
	Imbalance
	Fainting
	Seizures

Psychiatric:	[ ] None
	Anxiety
	Panic Attacks
	Depression
	ADD/ADHD

Endocrine:	[ ] None
	Cold intolerance
	Heat intolerance
	Increased thirst
	Frequent urination

Blood/Lymphatic:	[ ] None
	Anemia
	Bleeding
	Easy bruisability

Allergic/Immunologic:	[ ] None
	HIV/AIDS
	Anaphylaxis
	Recurrent infections
	Food Allergy
	Stinging Insect Allergy

OSA Symptoms:	[ ] None
	Excessive daytime sleepiness
	Restless sleep
	Snoring
	Awakening at night
	Nightmares
	Bruxism (gritting teeth)
	Jaw clenching
	Having to urinate at night
	Night sweats

Pregnancy:	[ ] N/A
	Pregnant
	LMP
	Breastfeeding

Change in medical/surgical/family/social history: [ ] No [ ] Yes _____
Change in home/work/environmental survey: [ ] No [ ] Yes _____
New Medications: _____

Rescue inhaler/neb used _____ times per [ ] day [ ] week [ ] month **[ ] No Known Drug Allergy**
Did you get a flu shot this year? Yes No **[ ] Drug Allergy** _____
If over age 65, have you received a pneumococcal vaccine? Yes No
Do you currently smoke? Yes No How much? _____
Have you smoked in the past? Yes No How much? _____ How Long? _____ Quit date _____