Allergy Sinus & Arthritis Clinic. PLLC

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Allergy Follow- Up Patient Information

Patient name: _____ Date of birth: _____

Reason for Follow up visit:_____

Present History: On a scale of 1-10, how much have your symptoms improved?
(Please write number, 10= 100% improved, 1= no improvement) _____

Which symptoms did not improve yet?_____

What allergy tablets_____ Nose spray_____ eye drops_____ and inhalers are you using.

How often do you take nose sprays and/or allergy tablets? (Please circle)
Don't use 1-2 days/week 3 days/week 5 days/week 7 days/week

New pets: _____ **Nosebleed with use of nose sprays?** Yes No

Use of saline nose spray or gel (ocean spray, Ayr saline gel) or Vaseline for dry nose? Yes No

Use of sinus rinses? Yes/No If yes, how often: _____ Tap water or distilled water? Helpful or not?

Discontinued or switched medication since last visit? Yes No If yes, which: _____
Why discontinued: _____ Was it helpful? Yes No

Asthma

Rate your Asthma on a scale of 1-10-(10 being very improved, 1 being no improvement at all): _____

Which asthma symptoms improved since last visit?_____

Which symptoms have not improved? _____

What inhalers are you using? _____ **Dose:** _____
Tolerating well? Yes No **Helpful or not helpful?** **Taking Singular?** Yes No

Frequency of asthma related symptoms (i.e. shortness of breath, wheezing, cough, chest tightness):
none less than 2 times/week greater than 2 times/week several times/day

Nocturnal symptoms: Yes/No If yes, how often: once a month twice a month twice a week more

Frequency of maintenance inhalers use: 0 days 1-2 days/week 3 days/week 5 days/week 7 days/week

Frequency of rescue inhaler use (Albuterol [Proair/Ventonil/Proventil]/ Levalbuterol [Xopenex] / Albuterol-ipratropium [Combivent]): less than 2 times/week greater than 2 times/week several times/day

Frequency of nebulizer use: less than 2 times/week great than 2 times/week several times/day

Which nebulizer medication: Albuterol Xopenex Duoneb (Albuterol-ipratropium)

Interference of daily activities: None Some limitation Extremely limited

Asthma exacerbation (needing steroids in last 6 months): Yes No If yes, when:_____

Asthma related hospitalization or urgent care or PCP visits in past 6 months? Yes No

Asthma related symptoms during exercise (eg: SOB, wheezing, cough, chest tightness): Yes No

Albuterol use before starting exercise? Yes No If yes, how many puffs and minutes before: _____

Discontinued or switched medication since last visit? Yes No If yes, which and Why: _____

Eczema

Rate your Eczema symptoms on a scale of 1-10-(10 =very improved, 1=no improvement at all): _____

Which symptoms improved? _____

Which symptoms have not improved? _____

Name of moisturizer used: _____ **How often:** _____

Name of topical cream or ointment used? _____ **Dose:** _____

Tolerating well? Yes No **Helpful or not helpful**

Flare ups since last visit? Yes No If yes, how many: _____ Interventions: _____

Intervention for itching: _____ **How often:** _____

Prednisone use for eczema: _____

Discontinued or switched medication since last visit? Yes No If yes, which: _____

Why discontinued: _____ **Was it helpful?** Yes No

Urticaria (Hives)

Rate your Urticaria symptoms on a scale of 1-10-(10=very improved, 1=no improvement at all): _____

Which symptoms improved? _____

Which symptoms have not improved? _____

Name of moisturizer used: _____ **How often:** _____

Name of topical cream or ointment used? _____ **Dose:** _____

Tolerating well? Yes No **Helpful or not helpful**

Flare ups since last visit? Yes No If yes, how many: _____ Interventions: _____

Intervention for itching: _____ **How often:** _____

Prednisone use for Urticaria: _____

Discontinued or switched medication since last visit? Yes No If yes, which: _____

Why discontinued: _____ **Was it helpful?** Yes No