Follow Up Patient Packet

Established Patient Update

1. Patient Name: ____________________ Date of Birth: ____________

   Gender:
   ○ Female ○ Male

   Primary Email: ____________

   Primary Phone: ____________

   Primary Care Physician First Name: ____________

   Primary Care Physician Last Name: ____________

   Primary Care Physician City: ____________

   Height: ____________ Weight: ____________

2. **If Patient is a minor please provide both parents full names below:**

   Father's First Name: ____________ Father's Last Name: ____________ Mother's First Name: ____________ Mother's Last Name: ____________

3. **Briefly describe the MAIN REASON(S) for this visit:**

4. **Please describe the MAIN OUTCOME you would like to obtain from this visit with our Allergy/Asthma/Immunology Specialist.**

5. **Do you currently take any prescription medications?**

   ☐ Yes ☐ No

6.

	Medication	Dosage/Frequency	Reason for Use
1			
2			
3			

7. Do you currently take any over-the-counter (OTC) medications regularly or as needed?

☐ Yes ☐ No

8.

	Medication	Dosage/Frequency	Reason for Use
1			
2			
3			

9. Do you currently have any specific FOOD allergies/intolerances?

☐ Yes ☐ No

10.

	Food Allergy/Intolerance	Symptoms Experienced
1		
2		
3		

11. Do you currently have any specific DRUG allergies/intolerances?

☐ Yes ☐ No

12.

	Drug Allergy/Intolerance	Symptoms Experienced
1		
2		
3		

13. Do you currently have any specific INSECT/CHEMICAL allergies/intolerances?

☐ Yes ☐ No

14.

	Insect/Chemical Allergy/Intolerance	Symptoms Experienced
1		
2		
3		

15. Have you received a flu vaccination for the current flu season?

○ Yes ○ No

○ Unknown

16. Have you received a Covid 19 shot this year?

- Yes
- No

17. If yes, please specify date:

___

18. If yes, please specify date:

___

19. Have you ever received the pneumonia shot called Pneumovax?

- Yes
- No
- Unknown

20. If yes, please specify date:

___

21. Have you ever received the pneumonia shot Prevnar 13?

- Yes
- No
- Unknown

22. If yes, please specify date:

___

23. Please indicate your preferred local Pharmacy:

Pharmacy Name: ___ Pharmacy Phone: ___

Pharmacy Street Address: ___ Apt./Unit #: ___ City: ___ State: ___ Zip Code: ___

24. Please indicate if you prefer liquid or tablet forms of medication, if available:

- Liquid
- Tablet

25. Please list any NEW information regarding your health since your last visit: (Indicate recent surgeries, illnesses, new diagnoses, etc:)

___

___

___

___

26. **Have you had any changes in your social status since your last visit (job, residence, tobacco/alcohol use/ allergen exposure)?**

- ○ Yes
- ○ No

27. **Please specify:**

____

____

____

____

28. **Have you had any changes in your Family History since your last visit (relative with new illnesses or disease)?**

- ○ Yes
- ○ No

29. **Please specify:**

____

____

____

____

30. **Review of Systems: Please check any signs/symptoms/conditions that you currently experience:**

Constitutional:
☐ Fatigue ☐ Night Sweats ☐ Fevers

Respiratory:
☐ Shortness of Breath ☐ Wheeze ☐ Cough ☐ Croup ☐ Tight chest

GI:
☐ Indigestion ☐ Reflux ☐ Vomiting ☐ Diarrhea ☐ Trouble Swallowing

Urinary:
☐ Urinary Infection ☐ Blood in Urine ☐ Back Pain

Frequent Infections:
☐ Sinus ☐ Lung ☐ Ear/Throat ☐ Bronchitis ☐ Skin

Musculoskeletal:
☐ Stiff/Sore Joints ☐ Muscle Pain ☐ Red Swollen Joints

Eyes:
☐ Blurry ☐ Itch ☐ Water ☐ Red ☐ Frequent Infections

Chest:
☐ Slow Heart Rate ☐ Palpitations ☐ Tight ☐ Chest Pain ☐ Fast Heart

Nose:
☐ Runny ☐ Stuffy ☐ Itchy ☐ Sneeze ☐ Loss of Smell ☐ Loss of Taste

Neuro:
☐ Numbness ☐ Seizures

Skin:
☐ Dry ☐ Itch ☐ Swelling ☐ Rash ☐ Hives

Psychology:
☐ Anxious ☐ Depressed ☐ Stressed ☐ Worried

Hematology:
☐ Unusual Bleeding ☐ Unusual Bruising ☐ Swollen Lymph Nodes

Endocrine:
☐ Weight Gain ☐ Weight Loss ☐ Increased Thirst ☐ Cold Intolerance ☐ Heat Intolerance

My signature indicates that the above information is accurate to the best of my knowledge.

Patient/Guardian

____
Signature