ASTHMA, ALLERGY CARE CENTER OF FLORIDA

Shahnaz Fatteh, M.D.

Board Certified Asthma, Allergy & Immunology: Adult & Pediatrics| Member: AAAAI, ACAAI, FAAIS

Program Director: AAI Fellowship, Nova Southeastern University

www.asthmaallergycare.com

NAME: _____ DOB: _____ DATE: _____ ID: _____

Thank you for coming to our office today. We need to update information *EACH visit.* Thus we are asking you to complete the following questions, whether the problems. Put a check: _√_ on any problems that you have. If you have no problems in the category, please mark "NO-PROBLEMS" line. If you need assistance with this form, please let us know.

REVIEW OF SYSTEMS QUESTIONNAIRE

Constitutional Systems ☐ **Check here if no problems in this category**

_____Fever _____Chills _____Weight Loss _____Fatigue _____Sweats

Eyes ☐ **Check here if no problems in this category**

_____Change in Vision _____Double Vision _____Itchy Eyes _____Watery Eyes

_____Pain in Eyes _____Dry Eyes _____Discharge from Eyes

Ears, Nose, Mouth, Throat ☐ **Check here if no problems in this category**

_____Ringing in Ears _____Nasal Congestion _____Discharge from Ears _____Pain in Ears

_____Sinus Pain _____Nasal Discharge _____Snoring _____Sore Throat

_____Postnasal Drip _____Hoarseness _____Mouth Breathing _____Nose Bleeds

Allergic / Immunologic ☐ **Check here if no problems in this category**

_____Allergies to Animal Dander (CATS / DOGS / BIRDS) _____Angioedema (SWELLING)

_____Infections requiring antibiotics more than three (3) times a year _____Pneumonia

_____Recurrent Ear Infections _____Recurrent Sinus Infections _____Food Allergies _____Peanut

_____Milk _____Soy _____Fish _____Shellfish _____Tree Nuts _____Other Food

_____Lactose (MILK) Intolerance _____Anaphylaxis _____Eosinophilic Esophagitis _____Food Intolerance

_____Delayed Wound Healing _____Autoimmune Disease _____Lupus _____Rheumatoid Arthritis

_____Thyroid Disease _____Cancer History _____Breast _____Colon _____Leukemia / Lymphoma

_____Other _____Urticaria (HIVES) _____Less than 3 weeks _____more than 3 weeks

Respiratory (LUNGS) ☐ **Check here if no problems in this category**

_____Shortness of Breath _____Wheezing _____Cough with Mucous _____Dry Cough

_____Shortness of Breath with Exercise _____Cough with Blood _____Pain with Deep Breath

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Skin ☐ **Check here if no problems in this category**

_____Rash _____Itching _____Bleeding/ Crusting/ Oozing of skin _____Hives _____Hair Loss

_____Rash with Sun Exposure _____Swelling of Skin (Lips/ Eyelids/ Extremities) _____Easy Bruising

_____Thinning of Skin _____Eczema _____Dermatitis

Cardiovascular ☐ **Check here if no problems in this category**

_____Chest Pain _____Skipped Heartbeats _____Palpitations _____Stents

_____Pain in Neck/ Jaw/ Left Shoulder _____History of Heart Attack _____Pacemaker

_____Swelling of legs _____Shortness of breath and walking _____Blood pressure problems

Gastrointestinal ☐ **Check here if no problems in this category**

_____Nausea _____Vomiting _____Constipation _____Diarrhea _____Irritable Bowel Syndrome

_____Colitis _____Reflux/ Heartburn _____Colon/ Stomach Cancer

_____Bleeding _____Stomach/ Peptic Ulcer _____Abdominal Pain

Musculoskeletal ☐ **Check here if no problems in this category**

_____Pain in Joints Where? _____

_____Swelling of Joints Where? _____

_____Osteoarthritis _____Pain in Calves _____Back Pain _____Joint Stiffness

Neurological ☐ **Check here if no problems in this category**

_____Seizure history _____Dizziness _____Light headedness _____Stroke _____Headache

_____Gait Abnormality _____Difficulty Speaking _____Numbness in Arms, Legs, Face

Endocrine ☐ **Check here if no problems in this category**

_____Diabetes _____Increased Thirst _____Frequent Urination _____Weight Gain _____Weight Loss

_____Hot/Cold Intolerance _____Enlarged Thyroid _____Thyroid Nodules

Hematologic/ lymphatic ☐ **Check here if no problems in this category**

_____Enlarged Lymph Nodes _____Easy Bruising _____Enlarged Spleen _____Easy bleeding

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Thank you for coming to our practice. Please fill out the information below so that we can keep accurate records. If you need help with any of the questions, we can assist you once you are in the exam room. Please place a check: _√_ next to your answer.

NAME: _____ DATE: _____

Social History: Adults (If you are a parent with a child, please mark answers for yourself)

_____Single _____Married _____Divorced _____Separated _____Partnership

_____Never Smoked _____Current Smoker _____No Drug Use _____Current Drug Use

_____If Working: Job: _____

Current or Recent Medications used for Patient to be Examined:

	Name of Medication	Dose	Frequency of use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Home Environment:

Home: Apt: _____ Condo: _____ Single Family Home: _____ Trailer: _____

Bedrooms: Carpeting: _____ Tile: _____ Wood: _____ Stone: _____ Laminate: _____

Ceiling Fans: _____ Standing Fan: _____ Stuffed Animals: _____ Air Conditioning: _____

Window Units: _____ Central A/C: _____ Pets (Cat / Dog / Birds): _____

How often are pets washed or groomed? _____ Live Plants? _____ How often are fans dusted? _____

How often are A/C filters changed? _____ Mold in the home? _____ Current or repaired leaks? _____

Feathers? _____