Revere Health Allergy & Immunology

Tammy Jacobs, MD • Joshua Burkhardt, DO

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**

DATE: ____/____/_____

Return Patient Form

Primary care doctor/provider: _____

If the patient has asthma, please also fill out an asthma control test form (back).
If instructed, fill out PHQ-9 (back).

Form completed by: ☐ Patient ☐ Parent/Guardian: _____

Review of Systems:

Please indicate any symptoms you (or your child) have experienced recently.

Constitutional: ☐ Fever ☐ Chills ☐ Fatigue ☐ Loss of appetite ☐ Weight loss ☐ Weight gain ☐ Sleep problems

Skin: ☐ Rash ☐ Itching ☐ Hives ☐ Dryness ☐ Frequent skin infections

Eyes: ☐ Itchy eyes ☐ Red eyes ☐ Burning eyes ☐ Watery eyes ☐ Swollen eyes ☐ Visual disturbances

Ears: ☐ Itchy ears ☐ Frequent ear infections ☐ Ear tubes

Nose: ☐ Itchy nose ☐ Sneezing ☐ Runny nose ☐ Nasal congestion ☐ Nose bleeds ☐ Nasal polyps ☐ Sinus pressure ☐ Sinus pain ☐ Frequent sinus infections

Mouth/Throat: ☐ Itchy mouth ☐ Swollen mouth ☐ Heart burn ☐ Difficulty swallowing (food stuck) ☐ Painful swallowing

Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness ☐ Exercise intolerance ☐ Frequent pneumonias ☐ Coughing up blood

Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ History of fainting ☐ High blood pressure ☐ Taking beta-blockers (ends in –lol)

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Blood in the stool ☐ Constipation ☐ Liver problems

Genitourinary: ☐ Kidney problems ☐ Kidney stones ☐ Frequent infections ☐ Incontinence

Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Joint swelling

Endocrine: ☐ Frequent urination ☐ Thirst ☐ Heat or cold intolerance

Hematologic/Oncologic: ☐ Anemia ☐ Easy bleeding or bruising ☐ Prone to blood clots ☐ History of blood transfusion ☐ Cancer

Allergic/Immunologic: ☐ Anaphylaxis (severe allergic reaction) ☐ Stinging insect anaphylaxis ☐ Penicillin allergy ☐ NSAID allergy ☐ Metal allergy ☐ Latex allergy ☐ Frequent infections

Neurological: ☐ Headache ☐ Migraines ☐ Seizures ☐ Learning problems ☐ Numbness/tingling in extremities

Psychiatric: ☐ Stress ☐ Depression ☐ Anxiety ☐ Behavioral problems

Other Symptoms: Please List: _____

Review of Systems Completed: _____
Patient Signature

Influenza Vaccine (this season from September to April): ☐ Yes ☐ No

If yes, approx. date: _____

If you have not received the flu shot this season, would you like it to be administered at this office visit? ☐ **Yes** ☐ No

If you have asthma, or if you are concerned about asthma, please fill out the **ASTHMA CONTROL TEST (ACT)** on the **back** of this form.

☐ I have filled out the ACT on the back.

Return Patient ROS v6 – 2/2/2021

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ____/____/_____ AGE: _____ SEX: M / F

DATE: ____/____/_____

Asthma Control Test™ Is:

- A quick test that provides a numerical score to assess asthma control.
- Recognized by the National Institutes of Health (NIH) in its 2007 asthma guidelines.[1]
- Clinically validated against spirometry and specialist assessment.[2]

For Patients 12 Years and Older:

1. Answer each question and write the answer number in the box to the right of each question.
2. Add your answers and write your total score in the TOTAL box shown below.
3. Discuss your results with your doctor.

									SCORE
1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?	All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5	
2. During the past **4 weeks**, how often have you had shortness of breath?	More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5	
3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5	
4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5	
5. How would you rate your **asthma** control during the **past 4 weeks**?	Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	
									TOTAL		

If your score is 19 or less, your asthma may not be under control. Be sure to talk with your doctor about your results. The answers below should not be added to your total score. These answers should be discussed with your doctor.

In the past 12 months, how many emergency department visits have you had due to asthma (that did not result in a hospitalization)? _____

Patient Health Questionnaire (PHQ-9)

Patient name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❒	❒	❒	❒
b. Feeling down, depressed, or hopeless.	❒	❒	❒	❒
c. Trouble falling/staying asleep, sleeping too much.	❒	❒	❒	❒
d. Feeling tired or having little energy.	❒	❒	❒	❒
e. Poor appetite or overeating.	❒	❒	❒	❒
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❒	❒	❒	❒
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❒	❒	❒	❒
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❒	❒	❒	❒
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

TOTAL SCORE _____