FOLLOW-UP PATIENT INFORMATION

We appreciate the opportunity to partner with you in the health of your child. We ask you to complete this information carefully and legibly. Thank you!

Do you have any Asthma Action Plan drugs on hand at home? (please circle all that apply.)

Albuterol Xopenex Orapred or Prednisolone Prednisone Medrol

List all current medications with dose and frequency and strength:

_____ _____

_____ _____

_____ _____

In the last week or two, have there been changes in health including flu or colds?
____NO ____YES (please describe)

_____

_____

SINCE YOUR LAST VISIT

Since last visit, have there been any respiratory complaints which caused:

Hospitalizations? ____NO ____YES When/How Many? _____

Emergency Room Visits? ____NO ____YES When/How Many? _____

Acute Doctor Visits? ____NO ____YES When/How Many? _____

Courses of Oral Steroids? ____NO ____YES When/How Many? _____

Since last visit, describe asthma control during a typical week when child is not ill:

Cough? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Activity/Exercise Interference? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Sleep Disturbance? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

Need for Albuterol/Xopenex? ____ NONE ____OCCASIONAL ___FREQUENT ____CONSTANT

None= less then weekly Occ= weekly, but frequent Frequent= almost daily Constant =daily, several times

Since last visit, please describe the following:

Allergic Rhinitis/Hay Fever? _____DON'T HAVE _____ CONTROLLED _____ NOT CONTROLLED

Atopic Dermatitis/Eczema? _____DON'T HAVE _____ CONTROLLED _____ NOT CONTROLLED

Gastroesopheal Reflux? _____DON'T HAVE _____ CONTROLLED _____ NOT CONTROLLED

SINCE YOUR LAST VISIT

Please list any recent symptoms or complaints in the following areas, since last visit:

Health Overall – for example change in appetite, chills, fatigue, weight gain or loss, etc.

____NO _____YES (describe) _____

Eyes – for example visual changes, blurred vision, eye drainage, sensitivity to light, etc.

____NO _____YES (describe) _____

Ears, Nose, and Throat – for example sore throat, hearing changes, sinus drainage, etc.

____NO _____YES (describe) _____

Heart – for example heart murmur, heart palpitations, chest tightness, dizziness, etc.

____NO _____YES (describe) _____

Stomach and Intestines – for example abdominal pain, change in stools, heartburn, indigestion

____NO _____YES (describe) _____

Bladder or Kidney – for example urinary problems, blood in urine, frequent bladder infections, etc.

____NO _____YES (describe) _____

Muscle or Skeleton – for example arthritis, back pain, joint stiffness or pain, weakness, etc.

____NO _____YES (describe) _____

Skin – for example change in moles, acne, rashes, sores, etc.

____NO _____YES (describe) _____

Neurological – for example fainting, headaches, memory problems, numbness or tingling, etc.

____NO _____YES (describe) _____

Psychological – for example anxiety, depression, mood swings, poor concentration, etc.

____NO _____YES (describe) _____

Diabetes/Thyroid – for example cold or heat intolerance, hair loss, excessive thirst, etc.

____NO _____YES (describe) _____

Bleeding/Anemia – for example blood clotting problems, easy bruising, excessive bleeding, etc.

____NO _____YES (describe) _____

Other?

_____