THIS FORM MUST BE COMPLETED ENTIRELY BEFORE THE PHYSICIAN CAN SEE YOU DUE TO REGULATIONS BY THE FEDERAL GOVERNMENT AND INSURANCE PLANS.

You may print this form prior to your visits by accessing www.allergytampa.com/medlist

CIRCLE: DR. LOCKEY DR. FOX DR. LEDFORD DR. GLAUM DR. CHO DR. PEPPER

PATIENT'S NAME _____ DATE OF BIRTH _____ DATE _____

YOUR HEIGHT _____ WEIGHT _____ BMI (if known) _____

CHIEF COMPLAINT: SYMPTOMS/PROBLEMS AS PREVIOUSLY DISCUSSED, CURRENT/ONGOING:

_____

NEW PROBLEMS SINCE LAST VISIT: _____

PREVIOUS PROBLEMS: STABLE _____ OR WORSENING (describe) _____

CIRCLE ALL APPLICABLE: Sneezing – Runny nose – Itchy eyes – Nasal Congestion – Throat clearing – Cough – Wheeze – Asthma – Shortness Of Breath – Hoarseness – Respiratory infection – Sinus pain – Sinusitis – Earache – Fever – Headache – Reflux – Heartburn – Rash – Hives – Food allergy – Drug allergy – Insect allergy – Allergic reaction to_____ (if known) - Itching of_____ (area) - Swelling of _____ (area)

REVIEW OF SYSTEMS: Are there any changes since your last visit? Please check.

___ Constitutional (weight loss, etc.)	**___ Cardiovascular**	**___ Neurological**
___ Allergy/Immunology	**___ Gastrointestinal**	**___ Endocrine**
___ Eyes	**___ Genitourinary**	**___ Hematologic/Lymphatic**
___ Ears, Nose, Mouth, Throat	**___ Musculoskeletal**	**___ Psychological**
___ Respiratory	**___ Skin**	

TOBACCO USER? ___Yes ___No If yes, do you want counseling on smoking cessation? ___Yes ___No
WEIGHT _____ Do you want counseling on weight regulation? ___Yes ___No
Receive (circle) these vaccines: FLU / PNEUMONIA / WHOOPING COUGH

PLEASE NOTE: MEDICATION LIST IS MANDATORY

LIST MEDICATIONS PRESCRIBED BY US DOSE TIMES TAKEN IN A DAY	**✓ If Refills Needed 30 day supply**	**90 day supply**
1		
2		
3		
4		
5		
6		
7		

MEDICATIONS PRESCRIBED BY OTHER PHYSICIANS AND OVER-THE-COUNTER MEDICATIONS YOU TAKE	
1	**5**
2	**6**
3	**7**
4	**8**

If indicated, circle if you have you had these procedures:

Colonoscopy Mammogram Pelvic PSA DEXA bone scan Cholesterol testing

HAVE ASTHMA? COMPLETE REVERSE SIDE OF FORM ACT SCORE

FOR MEDICAL STAFF: Does the patient wish counseling on smoking or weight issues? Circle codes on encounter form.

BP _____ P _____ R _____ TEMP _____ PF _____ BMI _____

ASTHMA CONTROL TEST (ACT)

This form must be completed by the patient to comply with insurance requirements / documentation.

Please circle **ONE** answer for each of the **5** questions below and review your results with your physician.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work 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 to 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)? **NOTE: Using before exercise or with exercise does not count.**

3 or more times per day **1**	1 to 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 SCORE _____ (please enter score on the other side of this form)

If your total score is 19 or less, your asthma may not be as well controlled as it could be.