PATIENT FOLLOW-UP INTAKE SHEET

Allergy and Asthma Center

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6824 Elm Street, Suite 120
McLean, VA 22101

DATE OF VISIT: _____

PATIENT NAME: _____ DOB: _____

ARE YOU TAKING A BETA BLOCKER? (A medication typically used for high blood pressure) YES: _____ NO_____

IF SKIN TESTING, HAVE YOU HAD AN ANTIHISTAMINE WITHIN THE PAST 5 DAYS? YES: _____ NO: _____

VITALS (Office use only):

BP: _____ HR: _____ TEMP: _____ HEIGHT: _____ ft. _____in. WEIGHT: _____ lbs.

PATIENT INFORMATION:

REASON FOR VISIT TODAY: _____

PRIMARY CARE PROVIDER: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS (Please list):

1) _____ 3) _____

2) _____ 4) _____

Pharmacy Name: _____ City/State: _____ Pharmacy #:_____

LIST ALL MEDICATIONS TAKING TO INCLUDE "OVER-THE-COUNTER" MEDICATIONS:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

HAVE YOU BEEN ON ANTIBIOTICS SINCE LAST VISIT? IF YES PLEASE INDICATE WHY:

_____

IF YOU HAVE ASTHMA, HAVE YOU HAD ANY ASTHMA EXACEBATIONS OR NEED OF INHALER/NEBULIZER SINCE LAST VISIT?

YES: _____ NO: _____