ALLERGY ASSOCIATES AND ASTHMA, LTD.		Date of service:	Page #
Dr. Suresh Anand	Dr. Miriam Anand	Veena Krause, F.N.P.	Tera Crisalida, PA-C
Tempe	Chandler	Mesa	
Patient's Name:		Paper Referral:	
Date of Birth:	Chart number:	Auth #	Expired Date:

Information below to be filled out by the Patient

Have you had any new medical issues since your last visit? For example, new diagnosis, surgery, hospitalization)
Yes / No

If yes, please describe: _____

_____

Do you have any allergies to any medications? Yes / No

If yes, please state the name of medications and describe the reactions: _____

_____

REVIEW OF SYSTEMS: Please check if you have had any of the following since your last visit. If not, check "None" for each.

GENERAL: □ None □ unexplained weight gain or loss □ unexplained fevers or shaking chills
□ waking up with your bedsheets or nightclothes soaking wet with sweat

BREASTS: □ None □ Breast lumps □ Nipple discharge

CARDIOVASCULAR: □ None □ palpitations/racing or fluttering of heart □ heart murmur
□ irregular heart rhythm □ swelling of the feet/ankles □ shortness of breath when lying flat

GENITOURINARY: □ None □ blood in urine □ trouble urinating □ history of kidney stones
□ waking up more than 3 times at night to urinate □ impaired kidney function

MUSCULOSKELETAL: □ None □ red, hot swollen joints □ pain in joints □ arthritis

NEUROLOGIC/PSYCHIATRIC: □ None □ seizures □ anxiety □ depression □ thoughts of suicide

LYMPHATIC: Have you noticed any enlarged or swollen lymph nodes that won't go away? □ No □ Yes
If yes, where? □ neck □ over the collar bones □ armpits □ borders between thigh and pelvis

Please list the name, location, and phone number of your preferred pharmacy:

_____

_____

Do you prefer a 30 day or 90 day supply for your prescriptions? 30 day 90 day

Have you started, changed, or stopped ANY of your medications since your last visit? (Please include ALL of your medicines, not just allergy or asthma medicines. (You may request a printed copy of the list of medicines that we have on record for you from the front desk.)
YES NO

Please continue to the other side

If yes, please list the changes (If you have an UP TO DATE list of your medicines with you, you may skip this section):

Added or changed:

MEDICATION:	DOSE:	FREQUENCY:	PRESCRIBING DOCTOR:

Stopped:

MEDICATION:	DOSE:	FREQUENCY:	PRESCRIBING DOCTOR:

ADDITIONAL HISTORY THAT YOU WANTED US TO KNOW:

For Staff Use Only:

Formulary:

Smoker? Never / Current / Former

Pets? No / Yes

CC: _____

HT	WT	P	BP	pO_2	Temp/other:

Staff initials