St. Paul Allergy & Asthma

PATIENT NAME: _____ **TODAY'S DATE:**_____

DATE OF BIRTH: _____

==========

Primary Care Provider (Name/Clinic): _____

_____

Can we send a letter back to your primary/referring provider(s)? ☐ **YES** ☐ **NO**

What are your primary goals for this visit/questions you have for your doctor?

☐ _____

☐ _____

☐ _____

☐ _____

PLEASE CHECK THE SYMPTOMS YOU ARE CURRENTLY/VERY RECENTLY EXPERIENCING:

GENERAL:

☐ Fatigue
☐ Fever
☐ Difficulty sleeping

EYES:

☐ Itchy
☐ Watery
☐ Red
☐ Puffy

EARS/NOSE/SINUSES/THROAT:

☐ Stuffy nose
☐ Runny nose
☐ Sneezing
☐ Itchy nose
☐ post-nasal drainage
☐ Facial pressure
☐ Poor sense of smell
☐ Nosebleeds
☐ Ear pain/fullness
☐ Snoring
☐ Sore throat
☐ Itchy throat

LUNGS:

☐ Chest tightness
☐ Wheezing
☐ Sputum/phlegm
☐ Shortness of breath
☐ Cough

HEART/BLOOD VESSELS:

☐ High blood pressure
☐ Irregular heartbeat
☐ Swelling in hands/ feet

GI TRACT:

☐ Heartburn
☐ Difficulty swallowing

SKIN:

☐ Eczema
☐ Hives
☐ Itching
☐ Swelling

LOCAL PHARMACY:

Name: _____
City: _____
Cross-streets: _____

MAIL-ORDER PHARMACY:

Name: _____