Academy Allergy Asthma and Sinus Center

Ashok Rambhai Patel, MD

Pueblo, Co 81004

Name: _____ **Nickname:**_____

Sex: M ▢ F ▢ DOB: _____ **Age:** _____ **Today'sDate:**_____

Primary Care Physician: _____ **Phone #:** _____

Pharmacy: _____ **Pharmacy Phone #:** _____

Reason for the visit: _____

_____

_____

Do you need a refill: Y ▢ N ▢ ***If yes, please write the name of the medications below:***

_____

_____

comments and questions for Dr. Patel:

_____

_____

_____

Please list all current medications, First, medications prescribed by Dr. Patel, then list all other medications: *If you take more medication, please add another paper if you need more space.*

Name of Medication:	How many pills/puffs?	How often?	When was it started?

CURRENT MEDICAL PROBLEMS:

Name of Medical Problem:	*Name of Medical Problem:*

Please try your best to fill in the information below:

	None	Mild	Mod	Sev
Cough	☐	☐	☐	☐
Waking up	☐	☐	☐	☐
Bedtime	☐	☐	☐	☐
In sleep	☐	☐	☐	☐
Triggers	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Talking	☐	☐	☐	☐
Laughing	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Talking	☐	☐	☐	☐
Laughing	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Talking	☐	☐	☐	☐
Laughing	☐	☐	☐	☐
Phlegm/Mucous	☐	☐	☐	☐
Blood in Sputum	☐	☐	☐	☐

	None	Mild	Mod	Sev
Sneezing	☐	☐	☐	☐
Nasal Itching	☐	☐	☐	☐
Nasal Congestion	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐
Post Nasal Drip	☐	☐	☐	☐
Nosebleed	☐	☐	☐	☐
Itchy Eyes	☐	☐	☐	☐
Watery Eyes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hives	☐	☐	☐	☐
Voice Changes	☐	☐	☐	☐
Fever	☐	☐	☐	☐
Chills	☐	☐	☐	☐

Sense of Smell

- ☐ Normal
- ☐ Decreased
- ☐ None

How often do you use rescue inhaler (Albuterol)?

_____/ day ____/ week ____/ month

Are you currently pregnant? ☐ Yes ☐ No

Age of gestation: _____

Any complications? _____

History of:	Yes	No	Current
Sleep Apnea	☐	☐	☐
Swelling of legs	☐	☐	☐
Blood clots in the lungs	☐	☐	☐
Heartburn	☐	☐	☐
Irregular heartbeat	☐	☐	☐
Diabetes	☐	☐	☐
Smoking **Packs/day:** _____	☐	☐	☐

Do you need a note for school or work?

- ☐ **Yes**
- ☐ **No**

What kind of note? _____

_____

If for meds, for what medication? _____

_____

Are your vaccinations up to date?

- ☐ **Yes**
- ☐ **No**

Patient/Guardian Signature: _____ Date:_____

Typing your name is equivalent to your handwritten signature

By typing my name and submitting this form electronically, I acknowledge that I have read and understood all information provided in this form. I agree that Ashok PC may rely on this information and that I am bound by its terms. I further acknowledge that my electronic signature is intended to serve as my legal signature and is equivalent to a handwritten signature.

For Office Use Only

Name: _____ DOB: _____ Date: _____
Account Balance: _____ Last Visit: _____
Any labs to be discussed? Y ▢ N ▢
Are any of the results Out of Normal range? Y ▢ N ▢ If yes, which ones? _____
_____
_____
X-Ray/CT Scan/Others? Y ▢ N ▢ Chest X-Ray: _____ CT Scan: _____
Need for spirometry? Y ▢ N ▢

What medications is the patient taking?

Name of Medication	*How many pills/ puffs?*	*How often?*	*When was it started?*

Patient's concerns and questions:

_____
_____
_____
_____
_____

Plan:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Address during Telemedicine: _____

Follow up: _____ ▢ Can Leave