

Chicago Family Asthma & Allergy
 2551 N Clark St, Ste 100, Chicago, IL 60641
 773-388-2322, Fax 773-388-2333
Chicagofamilyasthma.com



Follow-up Appointment

Patient: _____ DOB: _____ Date: _____

***New address, phone number, or insurance info?** **Please let us know at the front desk.**

PLEASE LIST ALL MEDICATIONS. Include inhalers, nasal sprays, eye drops, or injectors.
Please include doses and how frequently they are used, even those used as needed or in case of an emergency. Please circle or indicate any medicines you would like refilled.

Surgeries or hospitalizations since last visit? No Yes (explain): _____

Review of Systems Please check Yes or No:

System		System	
General:		Chest/Respiratory:	
Recent fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes:		Gastrointestinal:	
Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No
Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear, Nose, Throat:		Skin:	
Nasal congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No

Any furry pets in the home? No Yes (explain): _____

Any smoke exposure in the home? No Yes (explain): _____

Any drug allergies? No Yes (please list): _____
