Add Patient

Patient Name

Enter patient name..

Age

Enter patient age..

Sex

Select Gender

Referring physician

Enter Physician name

Address

Enter address

Contact No

Enter contact no

Email

Enter email address

Patient Id

Enter patient id

Have you ever had the following conditions	Yes	No
Hay fever (itching of nose, sneezing, stuffy nose, running nose)	○	○
Asthma (wheezing)	○	○
Other Breathing Problems - Shortness of Breath	○	○
Hives or Swelling (urticarial-angioedema)	○	○
Sinus Trouble - Frequent Colds	○	○

Have you ever had the following conditions	Yes	No
Eczema or other rashes (Poison Oak, Etc.)	○	○
Food Allergies	○	○
Arthritic Diseases	○	○
Immune Defect (frequent or recurrent infections)	○	○
Drug Allergy (Penicillin, Sulpha Aspirin, other)	○	○
Bee Sting or Insect Hypersensitivity (large swelling, hives, shock)	○	○

Details of Hay fever

Fever grade

○ Mild ○ Moderate ○ Severe

Itching sore throat and other symptoms if any

○ Yes ○ No

Any specific day/ exposure/cycles of fever if noted

Any specific day

Asthma

Select

How often have exacerbations occurred in the last year?

Write here..

Have these required any of the following and if so how frequently?

Admission to hospital	○ Yes ○ No
GP attendances	○ Yes ○ No
A&E attendances	○ Yes ○ No
Any ITU admissions in the past?	○ Yes ○ No
How many times are cough/wheeze present in a week	○ Yes ○ No
Are interval symptoms present?	○ Yes ○ No
Coughing at night how often does this wake the child	○ Yes ○ No
Early morning cough	○ Yes ○ No

Exercise induced symptoms ? ○ Yes ○ No

Does anyone in the family smoke? ○ Yes ○ No

Are there any pets at home ○ Yes ○ No

What triggers exacerbations? ☐ URTIs ☐ Cold weather ☐ Pollen ☐ Smoke ☐ Exercise ☐ Pets

Others, please specify

Allergic Rhinitis	Not So Much	Mild	Mod	Severe
Sneezing	○	○	○	○
Nasal Congestion	○	○	○	○
Running Nose	○	○	○	○
Itching Nose	○	○	○	○
Itching Eyes	○	○	○	○
Coughing	○	○	○	○
Wheezing	○	○	○	○

Allergic Rhinitis	Not So Much	Mild	Mod	Severe
Coughing or Wheezing	○	○	○	○
With Exercise	○	○	○	○
Headaches	○	○	○	○
Post Nasal Drip	○	○	○	○

Skin Allergy

Select

Heaves ○ Yes ○ No

Heaves Distribution

Eczema ○ Yes ○ No

Eczema Distribution

Ulcer ○ Yes ○ No

Ulcer Distribution

○ Yes ○ No

Papaulo-squamous rashes

Papaulo-squamous rashes Distribution

Itching with no rashes ○ Yes ○ No

Itching with no rashes Distribution

History

Hypertension ○ Yes ○ No

Diabetes ○ Yes ○ No

Epilepsy ○ Yes ○ No

IHD ○ Yes ○ No

Any New Drugs recently prescribed before the onset

Drug Allergy Known

Write here..

Probable

Write here..

Definite

Write here..

Occupation and Exposure possibility

Occupation

Probable Chemical Exposure

Write here

Write here

Location

Family History

Write here

Examination

Oral Cavity

Write here

Skin

Write here

ENT

Write here

Eye

Write here

Respiratory System

Write here

CVS

Write here

CNS

Write here

Abdomen

Write here

Any Other Findings

Write here

Investigations

Screening Test

Allergy Panel

Report

Choose File | No file chosen

Submit