(Office Only) MRN: _____

Revere Health Allergy & Immunology
Henry Yeates, MD • Tammy Jacobs, MD
Evangeline Lindorf, NP

PATIENT NAME: _____

DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**

Date: _____/_____/_____

Form completed by: ☐ Patient ☐ Parent/Guardian: _____

Review of Systems:

Please indicate any symptoms you (or your child) have experienced recently.

Constitutional: ☐ Fever ☐ Chills ☐ Fatigue ☐ Loss of appetite ☐ Weight loss ☐ Weight gain

Skin: ☐ Rash ☐ Itching ☐ Hives ☐ Dryness ☐ Frequent skin infections

Head: ☐ Headache ☐ Sinus pressure ☐ Sinus tenderness

Eyes: ☐ Itchy eyes ☐ Red eyes ☐ Burning eyes ☐ Watery eyes

Ears: ☐ Itchy ears ☐ Frequent ear infections ☐ Ear tubes

Nose: ☐ Itchy nose ☐ Sneezing ☐ Runny nose ☐ Nasal congestion ☐ Frequent sinus infections

Throat: ☐ Heart burn ☐ Difficulty swallowing ☐ Feeling food getting stuck ☐ Painful swallowing

Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness ☐ Frequent pneumonias

Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ History of fainting

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea Blood in the stool ☐ Constipation ☐ Liver problems

Genitourinary: ☐ Kidney problems ☐ Kidney stones ☐ Frequent infections ☐ Incontinence

Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Joint swelling

Endocrine: ☐ Frequent urination ☐ Thirst ☐ Heat or cold intolerance

Neurological: ☐ Seizures ☐ Learning problems ☐ Migraines ☐ Numbness/tingling in extremities

Psychiatric: ☐ Stress ☐ Depression ☐ Anxiety ☐ Behavioral problems

Other Symptoms: Please List: _____

Review of Systems Completed: _____

Patient Signature

Influenza Vaccine (this season from September to April): ☐ Yes ☐ No

If you have not received the flu shot this season, would you like it to be administered at this office visit? ☐ Yes ☐ No