Children's Hospital Boston

LABEL OR PRINT
NAME

CH MRN

DOB GENDER M F

ALLERGY / IMMUNOLOGY RETURN VISIT REPORT

Date ______________________ ☐ Patient identified by name and date of birth?

Diagnosis

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Medications

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Side effects ______________________

MDI technique ☐ good ☐ fair ☐ poor comments ______________________

Interval History:

Days wheezing ____________ Exercise Tolerance ____________
Nocturnal symptoms ____________ Admissions ____________
ER Visits ____________ School Absence ____________
Peak Flows: Pre ____________ PFTs ____________
Environment ______________________
Smoking status ______________________
General ______________________
HEENT ____________ Conj/sclera ____________ TMs ____________
Nose ______________________
OP ____________ Neck ____________
Chest ______________________
Cutaneous/Other ______________________

Lab Results ______________________

Assessment:

Plan/Orders:

______________________ MD

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