PATIENT FOLLOW-UP INTAKE SHEET

Allergy and Asthma Center
Anita N. Wasan MD PLC
6824 Elm Street, Suite 120
McLean, VA 22101

PATIENT NAME: ____ DOB: _______________________

ARE YOU TAKING A BETA BLOCKER? YES: __________ NO__________

IF SKIN TESTING, HAVE YOU HAD AN ANTIHISTAMINE WITHIN THE PAST 5 DAYS?

YES: _____ NO: _____

VITALS (FOR OFFICE USE ONLY):

BP: ___________ HR: __________ TEMP: _______________ HEIGHT: ______ ft. ________in.

WEIGHT: ________________ lbs.

PATIENT INFORMATION:

REASON FOR VISIT TODAY:

____

PRIMARY CARE PROVIDER:

____

ARE YOU ALLERGIC TO ANY MEDICATIONS (Please list):

1) ____

2) ____

3) ____

4) ____

Pharmacy Name: ______________________________ City/State: ____

Pharmacy #:_____________________

LIST ALL MEDICATIONS CURRENTLY TAKING (INCLUDE “OVER-THE-COUNTER” MEDICATIONS):

1.

2.

3.

4.

5.

6.