NORTH TEXAS ASTHMA AND ALLERGY CENTER

Gerald C. Moore, MD, PA **William T. Nguyen, MD** **Nitaya Thammasithiboon, FNP**

Date _____

Name _____ Date of Birth _____

Name of Referring Physician or PCP _____ When did we first see you? _____

Have you had any medical problems related to allergies or asthma since you were last here?
If yes please explain: _____

_____

_____

Specific Questions:

Asthma Attacks: Yes No Urgent Visits: Yes No

Nighttime Asthma: Yes No

Use of rescue inhalers more than 2 times per week? Yes No

Allergy shots? Yes No When did you start? _____ Problems with shots? Yes No

Medicine allergies? Yes No (Please List): _____

Do you need new prescriptions? Yes No

Mail In? Yes No Filled in Local Pharmacy? Yes No

Please list all of your medications currently being taken: Please place a check under Rx if you need filled.

Rx	Medication	Dosage(mg, tsp, puffs)	How many times daily	Every day	As Needed

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