

Demographic Form

ARC ID _____

Name: _____

Date: _____

Current Address:

Street _____

Apt # _____

City _____

State _____

Zip Code _____

Contact Information:

Phone # - Home _____

Phone # - Cellular _____

May we have your permission to text you? Yes No

Phone # - Work _____

E-Mail Address _____

Id Copy (Office use only)

Demographic Information:

Date of Birth	__ __ / __ __ / __ __ __ __
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Other: _____
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

Emergency Contact:

Name			
Address			
Phone # (Daytime)		Phone # (Evening)	
Relation			

Additional Contacts: Please provide the name, address, and phone #'s of 4 relatives or friends in the event that we cannot locate you or your emergency contact.

	Contact 1	Contact 2	Contact 3	Contact 4
Name				
Address				
Phone #				
Relation				

General Medical History Form

ARC ID _____

Name: _____

Date: _____

For Office Use Only: Place an * next to any item that requires additional comments and make a note in the comment section on page 4.

Please answer the following questions regarding your medical history. Questions about your respiratory history will be included on a different form.

Have you EVER been diagnosed with any the following? If so, please put an approximate start and stop date unless the condition is currently ongoing then, please write “-” or “n/a” in the Stop Date section.

Central Nervous System (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Anxiety						Headaches				
Depression						Stroke				
Epilepsy/Seizures						Sleep Apnea				
Parkinson's						Other Sleep Issues				
Other:										

MD Notes: _____

Eyes/Ears/Nose/Throat (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Cataracts						Nasal Polyps				
Glaucoma						Hearing Problems				
Rhinitis						Earaches				
Sinusitis						Other:				

MD Notes: _____

Endocrine (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date			Y	N	Start Date	Stop Date
Diabetes						Goiter				
Hypothyroid						Hyperthyroid				
Other:										

MD Notes: _____

Heart/Vascular (Please check Y or N and include Start/Stop Date, as necessary)									
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date
					Murmur				
Anemia					Aneurysm				
Heart Attack					Valve Disease				
High Blood Pressure					Rheumatic Fever				
Congestive Heart Failure					Syncope/fainting				
Angina					Other:				

MD Notes: _____

Gastrointestinal (Please check Y or N and include Start/Stop Date, as necessary)									
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date
Ulcer					Bloody Stool				
Constipation					Gall Bladder Problem				
Chronic Diarrhea					Pancreatic Problem				
Hepatitis A/B/C					Indigestion				
Jaundice					Cirrhosis				
Other:									

MD Notes: _____

Musculoskeletal (Please check Y or N and include Start/Stop Date, as necessary)									
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date
Broken Bones					Bursitis				
Back Problems					Tendonitis				
Arthritis					Other:				

MD Notes: _____

Urinary Tract (Please check Y or N and include Start/Stop Date, as necessary)									
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date
Urinary Frequency					Incontinence				
Urgency					Chronic Urinary Tract Infections				
Other:									

MD Notes: _____

Immune/Neoplastic (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date	
Cancer						Leukemia				
Abnormal Growth						Lymphoma				
Tumors						HIV Positive				
Other:										

MD Notes: _____

Skin (Please check Y or N and include Start/Stop Date, as necessary)										
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date	
Eczema						Psoriasis				
Melanoma						Skin Cancer				
Other:										

MD Notes: _____

Reproductive (Please check Y or N and include Start/Stop Date, as necessary)										
FEMALES:										
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date	
Hysterectomy						Post-Menopausal				
Tubal Ligation						Ovarian Cyst				
Irregular Periods						Ovarian/Uterine				
Other:						Cancer				

What method of birth control are you currently using? _____

MD Notes: _____

Reproductive (Please check Y or N and include Start/Stop Date, as necessary)										
MALES:										
	Y	N	Start Date	Stop Date		Y	N	Start Date	Stop Date	
Vasectomy						Testicular Cancer				
Prostatitis						Other:				

Have you ever had a skin test for tuberculosis (TB)? YES NO
 ⇒ IF YES: When was the test done? _____
 What were the results of your test? * POSITIVE NEGATIVE
 ⇒ IF POSITIVE: When was the last positive test? _____

Have you ever had a confirmed diagnosis of COVID? YES NO
 ⇒ If YES, when? _____

Were you born prematurely (less than 35 weeks)? YES NO
 ⇒ IF YES: At how many weeks gestation? _____

ILLNESSES, OPERATIONS, HOSPITALIZATIONS, INJURIES

Please list any major illnesses, operations, hospitalizations, major injuries or other important medical conditions that you have had during your lifetime and have **NOT** listed above.

<i>Major illnesses, operations, hospitalizations, major injuries</i>	<i>Year</i>	<i>Still troublesome/present (Yes/No)</i>

On average, how much of the following alcoholic beverages do you drink per week?

Glasses of wine: _____ cans/bottles of beer: _____ shots of hard liquor: _____

- Has anyone ever told you to cut back on your drinking? YES NO
- Have you ever felt guilty about your drinking? YES NO
- Have you ever missed work or been hospitalized because of your drinking? YES NO
- Do you use any recreational drugs such as cocaine, crack, IV drugs? YES NO
- If yes ⇒ When was the last time? _____

MEDICATION HISTORY

Please list all medications you have taken in the past **6 weeks** including over-the-counter medications, sprays, injections, vaccines, etc.

MEDICATION (e.g. Advair)	DOSE (e.g. 500/50)	FREQUENCY (e.g. 1 puff Twice/Day)	START DATE (e.g. 01/01/2016)	STOP DATE (e.g. Current)	REASON (e.g. Asthma)

FAMILY HISTORY:

Are there any diseases that run in your family?

Disease	Yes	No	Family Member	At what age
Stroke				
Heart Attack				
Angina				
High Blood Pressure				
Diabetes				
Breast Cancer				
Other				
Other				
Other				

Additional Coordinator or Physician Notes/Comments:

Respiratory History Form

Name: _____

Date: _____

For Office Use Only: Place an * next to any item that requires additional comments and make a note in the comment section on page 4.

Please answer the following questions regarding your respiratory health.

Please indicate if you have EVER had any of the following confirmed by a doctor			
	Yes	No	Unsure
Asthma			
Emphysema			
Chronic bronchitis			
Chronic Obstructive Pulmonary Disease (COPD)			
RH1 Eczema			
RH2 Hay Fever			
RH3 Nasal Polyps			
Pneumonia			
Acute Bronchitis			
Tuberculosis			
Lung Cancer			
Other			
I do not have any of these conditions/symptoms			

MD Notes: _____

Do any of the following cause attacks of wheezing or shortness of breath? (please place an X)					
	Yes	No		Yes	No
RH4 Exercise				Fatigue	
Colds				Odors	
RH5 Cold Air				Foods	
Humidity				Stress	
RH6 Aspirin				Other: _____	

If you don't have Asthma please skip to Page 9
(Have you ever been skin tested for allergies?)

RH7 At what age did you first develop asthma? _____ I do not have asthma

	Yes	No	Unsure
Do you produce sputum on a daily basis?			
Do you cough on a daily basis?			
Do you wake up at night because of your respiratory condition or to use your inhaler?			
If yes, how many nights on average do you wake up a week?	_____ nights		
Do you need to use oxygen?			
If yes, how much do you use and when?			

Please check the months when your respiratory symptoms are the worst:				
January			July	
February			August	
March			September	
April			October	
May			November	
June			December	

Please check when your daily symptoms are the worst:				
Morning			Night	
Home			Work	
Indoors			Outdoors	

ASTHMA AND ALLERGY MEDICATION HISTORY:						
Please list all medications you have taken for your RESPIRATORY (Allergy and Asthma) condition in the past 6 wks.						
	MEDICATION (e.g. Advair)	DOSE (e.g. 500/50)	FREQUENCY (e.g. 1 puff Twice/Day)	START DATE (e.g. 01/01/2016)	STOP DATE (e.g. Current)	REASON (e.g. Asthma)
M1						
M2						
M3						
M4						
M5						
M6						

BA On average, how many times per week do you take your “rescue inhaler” (Ventolin, Albuterol, Proair, etc.)?
_____ times

Have you EVER taken inhaled corticosteroids (such as Azmacort®, Flovent®, Pulmicort®, Advair®, Symbicort®, Dulera®, Qvar®, Beclovent®, Alvesco®, Azmacort® Breo Ellipta®, Anoro Ellipta® etc.) for your respiratory condition?

YES NO

⇒ If YES, list medication and start/stop date:

Medication Start Date Stop Date (Write "current" if still taking)

Does your asthma worsen when the dose of your steroid medication is reduced or missed? YES NO

Have you ever been prescribed injections for your asthma other than steroids? (i.e., Xolair (omalizumab), Nucala (mepolizumab), Fasentra (benralizumab), & Dupixent (dupilumab)?)

YES NO

RH8 For Office Use Only: Is the participant currently taking inhaled corticosteroids on a regular basis? Yes No

Please answer the following questions regarding your respiratory condition/allergy history. (Circle Y/N and fill in blanks as necessary)

**RH8A
RH8B**

Have you ever taken oral steroids (such as prednisone, Medrol, etc.) for your respiratory condition? Have you EVER taken "bursts" of prednisone? If YES: How many times in the last year? How many times in last 10 years? If YES, list medication and start/stop date: Medication Start Date Stop Date _____ _____	Yes	No
Have you ever taken steroid shots in your arm or leg for your respiratory condition? If YES, list medication and start/stop date: Medication Start Date Stop Date _____ _____	Yes	No

Please answer the following questions regarding your respiratory condition/allergy history. (Circle Y/N and fill in blanks as necessary)

RH9

RH10

In the past 12 months have you had an unscheduled visit to a medical provider for an asthma attack or wheezing care? (i.e., office visit, urgent care intervention, emergency department, or hospitalization)	Yes	No
Have you ever had to go to the emergency room for your respiratory condition? If YES, when was the last time? How many times in the last year? How many times in last 10 years	Yes	No
Have you ever had to stay overnight in the hospital for your respiratory condition? If YES, when was the last time? How many times in the last year? How many times in last 10 years?	Yes	No
Have you ever been intubated (had a tube inserted in your throat to help you breathe) for your respiratory condition? If YES, when was the last time?	Yes	No

Please check if you have any of the following allergies and describe symptoms:

	Check	What kind?	What symptoms do you experience?
RH11	Animals		
	Pollen		
	Dust		
RH12	Food		
	Drugs		

Have you ever been skin tested for allergies? YES NO

Have you ever received allergy shots? YES NO

If YES, are you still receiving them? YES NO

If NO, when did you stop receiving them? _____

Has anyone in your immediate family ever had:

	Parent	Brother(s)/Sister(s)	Children?
RH13	Asthma		
	Hay Fever		
	Hives		
	Eczema		
	Swelling		

Please answer the following questions regarding your respiratory condition/allergy history. (Circle Y/N and fill in blanks as necessary)

RH14	Have you ever smoked (cigarettes, cigar, pipe)?	Yes	No
	If NO: Stop here.		
	If YES, Are you a smoker now?	Yes	No
	If YES: How many packs per day do you smoke?		
	What year did you start smoking?		
	If NO: How many packs per day did you smoke?		
	How many years did you smoke?		
	When was your last cigarette?		
	Do you regularly smoke marijuana or use vapes?	Yes	No

RH15 *Coordinator Use:* Calculated # of pack years _____ (= packs smoked per day x years smoked)

RH16 *Coordinator Use:* *ASTHMA* *NORMAL* *COPD*

I verify that the above information is accurate. _____
Subject signature Date

I verify that I have reviewed the above information. _____
Coordinator Signature Date

Coordinator Verification of Asthma Medication (must select at least 1 option):

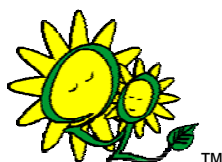
- Coordinator saw and photographed inhalers that subject brought in during appointment. Photo will be saved in ARC subject chart**
- Subject showed active prescription through patient's medical/pharmacy portal. Snippet was emailed and will be saved in ARC subject chart.**
- Coordinator verified/printed active prescription via EPIC/Care Everywhere.**

Coordinator Initials: _____ **Date:** _____

ASTHMA CONTROL QUESTIONNAIRE

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December 2002

Please answer questions 1 - 6.

Circle the number of the response that best describes how you have been during the past week.

- | | |
|---|---|
| 1. On average, during the past week, how often were you woken by your asthma during the night? | 0 Never
1 Hardly ever
2 A few times
3 Several times
4 Many times
5 A great many times
6 Unable to sleep because of asthma |
| 2. On average, during the past week, how bad were your asthma symptoms when you woke up in the morning? | 0 No symptoms
1 Very mild symptoms
2 Mild symptoms
3 Moderate symptoms
4 Quite severe symptoms
5 Severe symptoms
6 Very severe symptoms |
| 3. In general, during the past week, how limited were you in your activities because of your asthma? | 0 Not limited at all
1 Very slightly limited
2 Slightly limited
3 Moderately limited
4 Very limited
5 Extremely limited
6 Totally limited |
| 4. In general, during the past week, how much shortness of breath did you experience because of your asthma? | 0 None
1 A very little
2 A little
3 A moderate amount
4 Quite a lot
5 A great deal
6 A very great deal |

- | | | | |
|----|--|---|--|
| 5. | In general, during the past week, how much of the time did you wheeze ? | 0 | Not at all |
| | | 1 | Hardly any of the time |
| | | 2 | A little of the time |
| | | 3 | A moderate amount of the time |
| | | 4 | A lot of the time |
| | | 5 | Most of the time |
| | | 6 | All the time |
| | | | |
| 6. | On average, during the past week, how many puffs/inhalations of short-acting bronchodilator (e.g. Ventolin/Bricanyl) have you used each day?
<i>(If you are not sure how to answer this question, please ask for help)</i> | 0 | None |
| | | 1 | 1 - 2 puffs/inhalations most days |
| | | 2 | 3 - 4 puffs/inhalations most days |
| | | 3 | 5 - 8 puffs/inhalations most days |
| | | 4 | 9 - 12 puffs/inhalations most days |
| | | 5 | 13 - 16 puffs/inhalations most days |
| | | 6 | More than 16 puffs/inhalations most days |

To be completed by a member of the clinic staff

- | | | | |
|----|--|---|-----------------|
| 7. | FEV ₁ pre-bronchodilator: | 0 | > 95% predicted |
| | | 1 | 95 - 90% |
| | FEV ₁ predicted:..... | 2 | 89 - 80% |
| | | 3 | 79 - 70% |
| | FEV ₁ %predicted:..... | 4 | 69 - 60% |
| | (Record actual values on the dotted lines and score the FEV ₁ % predicted in the next column) | 5 | 59 - 50% |
| | | 6 | < 50% predicted |