Case ID #_____

Self Assessment Case Record Checklist - IMMUNODEFICIENCY

	Documented (check) YES	NO
1. Is there a description of problems with chronic, recurrent or severe infections?	O	O
2. Is there a description of growth (for children) or weight change (for adults)?	O	O
3. Is there a description of autoimmune or chronic inflammatory diseases, or statement that these symptoms have been absent?	O	O
4. Is the immunization history recorded?	O	O
5. Is the family history recorded?	O	O
6. In the physical exam, is there a description of lymphoid tissue (tonsils, lymph nodes, spleen)?	O	O
7. In the physical exam, is there a description of the nasal cavities, tympanic membranes, oral mucosa and gingivae?	O	O
8. In the physical exam, is there a description of the breath sounds?	O	O
9. In the physical exam, is there a description of the skin and nails?	O	O
10. Are laboratory results reported or pending in the chart?		
CBC/differential	O	O
Serum immunoglobulin levels	O	O
Antibody responses to vaccines	O	O

Conclusions from review:

_____

_____

_____

_____

_____ _____ _____

Fellow's Name **Date** **Clinic (Day & AM/PM)**

Reviewed & Accepted: _____ _____

Attending Physician Signature **Date**

Case ID # _____

Self Assessment Case Record Checklist –FOOD ALLERGY

Were the following elements addressed in the history:	Documented (check) Yes	No
Onset of symptoms	O	O
Type of symptoms	O	O
Duration of symptoms	O	O
Temporal pattern of symptoms	O	O
Severity of symptoms	O	O
Respiratory compromise	O	O
Specific foods suspected of causing reactions	O	O
Specific foods being avoided	O	O
How strictly each food is being avoided	O	O
Other atopic history		
Atopic dermatitis	O	O
Asthma	O	O
Allergic rhinitis	O	O
Drug allergy	O	O
Previous diagnostic tests and results	O	O
Current medications	O	O
EpiPen prescription	O	O
Family history of atopy	O	O
Environmental history	O	O
Social history	O	O
Review of systems	O	O

Were the following elements described in the physical exam?	Yes	No
Skin	O	O
TM's	O	O
Nose	O	O
Oropharynx	O	O
Neck	O	O
Chest	O	O
Cardiovascular	O	O

Conclusion:

_____

_____

_____

_____

_____ _____ _____

Fellow's Name **Date** **Clinic (Day & AM/PM)**

Reviewed & Accepted: _____ _____

Attending Physician Signature **Date**

(Food Allergy Checklist – 03/09/09)

Case ID # _____

Self Assessment Case Record Checklist –ASTHMA

I. Were the following elements addressed in the history?	Documented (check) YES	NO
Onset of symptoms [age; _____year _____]	O	O
Duration of symptoms	O	O
Seasonality vs chronicity of symptoms [spring; _____; summer_____; fall _____; winter; _____]	O	O
Allergic triggers of symptoms [pollens ___; molds ___;dust ___; animals ___; insects ___; other ___]	O	O
Non-allergic triggers of symptoms	O	O
Type of symptoms [chest tightness/cough/wheezing/shortness of breath/chest pain/other]	O	O
Frequency of symptoms [daily vs # days/week]	O	O
Severity of symptoms [mild/moderate/severe/incapacitating]	O	O
Impact on quality of life	O	O
Effect on job (work) or school performance	O	O
Does condition awaken you from sleep	O	O
Does condition worsen with exercise	O	O
Does condition result in ER visits [#___/year; when last occurred _____]	O	O
Does condition result in hospitalization [# ___/year; when last occurred _____]	O	O
Does patient have related respiratory conditions [rhinitis/sinusitis/bronchitis/emphysema/GERD; if so, then describe]	O	O
Types of medications used in past	O	O
Current medication regimen	O	O
Previous diagnostic tests and records [blood tests/CXR/chest CT scan/ sinus x-ray/CT scan/pulmonary function testing/ methacholine challenge]	O	O

	Documented (check) YES	NO
Allergy profile	O	O
Past history	O	O
Family history	O	O
Environmental history	O	O
Work/school history	O	O
Social history	O	O
Review of systems	O	O

II. Were the following elements described in the physical exam?

HEENT	O	O
Conjunctiva [injected/secretions]	O	O
Tympanic membranes [retracted/fluid]	O	O
Nasal mucosa [erythema/edema/secretions/erosions/ulcerations/ polypoid tissue]	O	O
Sinuses [tenderness]	O	O
Oral pharynx [erythema/pus/secretions]	O	O
Neck [lymph node enlargement/tenderness/bruits/thyroid enlargement]	O	O
Chest: [auscultation (wheeze/rales/rhonchi/rub); percussion; egophony; fremitus]	O	O
Cardiovascular [rate/rhythm/murmur/gallop/rub]	O	O

Conclusion: _____

_____

_____

_____

_____ _____ _____

Fellow's Name **Date** **Clinic (Day & AM/PM)**

Reviewed & Accepted: _____ _____

Attending Physician Signature **Date**

Case ID # _____

Self-Assessment Case Record Checklist – ANGIOEDEMA/URTICARIA

Angioedema Checklist ☐ **Not Applicable**

History elements:	**Documented (circle) Yes**	**No**
1) Description of first episode	O	O
2) Total number of episodes	O	O
3) Involved sites- association with abdominal pain/diarrhea?	O	O
4) Frequency of episodes (daily/ weekly/monthly)	O	O
5) Pattern : stable, increasing or decreasing severity / frequency	O	O
6) Temporal pattern within a single day	O	O
7) Duration of average episode	O	O
8) Triggering factors (e.g.Trauma)	O	O
9) Family history of angioedema	O	O
10) Respiratory or cardiovascular compromise	O	O
11) Coincident with urticaria	O	O
12) Need for epinephrine	O	O
13) Medication associations: (ACEI, ASA, Estrogens)	O	O
14) Associations with menstrual cycle or preganancy	O	O
15) Symptoms (pain, numbness, itching)	O	O

Chronic Urticaria checklist ☐ **Not Applicable**

History elements:	**Documented (circle) Yes**	**No**
1) Description of first episode, prior history of urticaria	O	O
2) Description of lesions and involved sites	O	O
3) Frequency of episodes (daily/ weekly/monthly)	O	O
4) Pattern : stable, increasing or decreasing severity / frequency	O	O
5) Temporal pattern within a single day	O	O
6) Duration of average event single lesion	O	O
7) Triggering factors --ASA, post-prandial, stress	O	O
8) Family history of urticaria, autoimmune disease, thyroid disease?	O	O
9) Physical triggers-cold, heat, trauma, dermatographic	O	O
10) Medication /Food associations	O	O

11) Purpuric and/or residual tenderness	O	O
12) Resolution of lesions without permanent skin changes	O	O
13) Symptoms (pain, numbness, itching)	O	O
14) Pt. H/o autoimmune disorders, thyroid disease	O	O
15) Skin biopsy	O	O

Physical Exam Checklist

	Documented (circle)		
	Yes	**No**	**N.A.**
1) Urticaria characterization;			
a. size	O	O	O
b. number	O	O	O
c. location	O	O	O
d. linear versus circumferential	O	O	O
e. Blanchable	O	O	O
2) Dermographism present	O	O	O
3) Palpation for enlarged thyroid, pre-tibial edema, signs of hypo/hyper thyroidism	O	O	O
Laboratory w/u: if clinically indicated			
) CBC with differential, LFTs	O	O	O
2) TSH, anti-thyroglobulin and anti-microsomal Abs	O	O	O
3) Lupus package- if photosensitivity, oral ulcers, unexplained fevers and either long-lasting lesions (>>24hr) or nonblanching lesions.	O	O	O
4) SPEP- if angioedematous lesions, fevers/malaise	O	O	O
5) Skin biopsy if concerned about vasculitis (or other diseases in differential- Bullous Pemphigoid, etc) or if routine treatment (antihistamines ± LT antagonists) do not work	O	O	O
Therapies:			
◦ Antihistamines	O	O	O
◦ LT antagonists	O	O	O
◦ Thyroid replacement (if hypothyroid)	O	O	O
◦ Steroids	O	O	O
◦ Immunomodualtors (Sulfasalazine,cyclosporine, dapsone, colchicine, Hydoxychloroquine)			

Conclusions from review:

_____

_____

_____

_____

Fellow's Name	Date	Clinic (Day & AM/PM)

Reviewed & Accepted: _____ _____

Attending Physician Signature | Date

Case ID # _____

Self Assessment Case Record Checklist - RHINOSINUSITIS / CONJUNCTIVITIS

	Documented (check)	
Were the following elements addressed in the history?	**YES**	**NO**
Onset of symptoms	⑥	⑥
Type of symptoms	⑥	⑥
Duration of symptoms	⑥	⑥
Frequency of symptoms	⑥	⑥
Severity of symptoms	⑥	⑥
Impact of disease	⑥	⑥
Temporal pattern of symptoms	⑥	⑥
Environmental pattern of symptoms	⑥	⑥
Allergenic trigger factors	⑥	⑥
Non-allergenic trigger factors	⑥	⑥
Co-morbidities	⑥	⑥
Previous diagnostic tests and results	⑥	⑥
Previous over-the-counter treatment and results	⑥	⑥
Previous prescription treatment and results	⑥	⑥
Personal history of atopy	⑥	⑥
Family history of atopy	⑥	⑥
Were the following elements described in the physical exam?	**YES**	**NO**
Skin	⑥	⑥
Conjunctivae	⑥	⑥
Tympanic membranes	⑥	⑥
Nasal mucosa color	⑥	⑥
Nasal turbinate size	⑥	⑥
Nasal discharge	⑥	⑥
Nasal polyps presence or absence	⑥	⑥
Oropharynx	⑥	⑥
Sinus tenderness presence or absence	⑥	⑥
Cervical lymph nodes	⑥	⑥
Breath sounds	⑥	⑥

Conclusions from review:

_____

_____

_____

_____

_____	_____	_____
Fellow's Name	Date	Clinic (Day & AM/PM)

Reviewed & Accepted: _____ _____

Attending Physician Signature | Date

Case ID #_____

Self Assessment Case Record Checklist – DRUG HYPERSENSITIVITY

History- For each drug reaction, record	Documented (check) YES	NO	NA
1. Reaction description	O	O	O
---- Important negatives: pruritis, urticaria, exfoliation	O	O	O
2. Date (Year) of reaction or time lapse since	O	O	O
3. Time from start treatment to onset reaction	O	O	O
4. Other concomitant medications (list vs. none)	O	O	O
5. Subsequent treatment with same and/or related drugs	O	O	O
6 Previous evaluations (eg pen STs , rechallenge)	O	O	O
7. Current or projected need for drug	O	O	O

PMH	YES	NO	NA
1. Medical conditions now requiring culprit drugs	O	O	O
2. Atopic diathesis	O	O	O
3. Current medications (esp beta blockers, ACE inh.)	O	O	O

P.E. (assumes post-hoc evaluation)	YES	NO	NA
1. Skin: dermatitis, including stigmata of chronic pruritis; necklace-distribution rubor; vasculitic lesions; mucus membrane involvement	O	O	O

Lab	YES	NO	NA
1. Skin tests where potentially informative	O	O	O
2. Autoimmune diathesis (cf. urticaria, vasculitis)	O	O	O
3. Systemic markers if ongoing (eosinophilia, ESR, tryptase)	O	O	O
4. Supervised challenge/ desensitization	O	O	O

Assessment / Plan	YES	NO	NA
1. Clear opinion re: risk of retreatment and/or rank-order likelihood culprits	O	O	O
2. Recommendation for way forward	O	O	O

Conclusions from review:

_____

_____

_____

_____

_____ _____ _____

Fellow's Name **Date** **Clinic (Day & AM/PM)**

Reviewed & Accepted: _____ _____

Attending Physician Signature **Date**

Case ID # _____

Self Assessment Case Record Checklist - Eosinophilic Disorders

Were the following elements addressed in the history?	Documented (check) YES	NO
Onset of symptoms	⑥	⑥
Type of symptoms	⑥	⑥
Organ specificity of symptoms	⑥	⑥
Duration of symptoms	⑥	⑥
Frequency of symptoms	⑥	⑥
Severity of symptoms	⑥	⑥
Impact of disease	⑥	⑥
Travel history	⑥	⑥
Onset of eosinophilia	⑥	⑥
Magnitude and duration of eosinophilia	⑥	⑥
Biopsy results or other tests documenting eosinophilic organ system involvement	⑥	⑥
Other previous diagnostic tests and results	⑥	⑥
Previous prescription treatment and results including response of eosinophilia to any treatments	⑥	⑥

Were the following elements described in the physical exam?	YES	NO
Skin	⑥	⑥
Nasal mucosa/polyps	⑥	⑥
Oropharynx	⑥	⑥
Lungs	⑥	⑥
Heart	⑥	⑥
Hepatosplenomegaly	⑥	⑥
Lymphadenopathy	⑥	⑥

Case ID # _____

Self Assessment Case Record Checklist- ATOPIC DERMATITIS

	Documented (check) YES	NO
1. Personal history of atopic disease	O	O
2. Pruritus	O	O
3. Duration of dermatitis	O	O
4. Description of dermatitis (Xerosis, ichthyyosis etc.)	O	O
5. Distribution of dermatitis	O	O
6. Triggering, aggravating, and alleviating factors	O	O
7. Response to anti-inflammatory agents (corticosteroids, calcineurin inhibitors)	O	O
8. History of cutaneous infection and treatment (Staphylococcus aureus, herpes simplex, vaccinia, warts, and molluscum contagiosm)	O	O
9. History of sino-pulmonary, and GI infections	O	O
10. Family history of atopy	O	O
11. Course influenced by environmental factors	O	O
12. Course influenced by emotional factors	O	O
13. Constitutional symptoms (abdominal pain, fever, myalgia, arthralgia, night sweats, and weight loss)	O	O

Conclusions from review:

_____

_____

_____

Case ID # _____

_____

Fellow's Name	Date	Clinic (Day & AM/PM)

Reviewed & Accepted: _____ _____

Attending Physician Signature | Date

03/09/2009