

Self Assessment Case Record Checklist - IMMUNODEFICIENCY

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

Conclusions from review:

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

Attending Physician Signature	Date
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Self Assessment Case Record Checklist –FOOD ALLERGY

Were the following elements addressed in the history:	Documented (check)	
	Yes	No
Onset of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Type of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Duration of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Temporal pattern of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Severity of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory compromise	<input type="checkbox"/>	<input type="checkbox"/>
Specific foods suspected of causing reactions	<input type="checkbox"/>	<input type="checkbox"/>
Specific foods being avoided	<input type="checkbox"/>	<input type="checkbox"/>
How strictly each food is being avoided	<input type="checkbox"/>	<input type="checkbox"/>
Other atopic history		
Atopic dermatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>
Drug allergy	<input type="checkbox"/>	<input type="checkbox"/>
Previous diagnostic tests and results	<input type="checkbox"/>	<input type="checkbox"/>
Current medications	<input type="checkbox"/>	<input type="checkbox"/>
EpiPen prescription	<input type="checkbox"/>	<input type="checkbox"/>
Family history of atopy	<input type="checkbox"/>	<input type="checkbox"/>
Environmental history	<input type="checkbox"/>	<input type="checkbox"/>
Social history	<input type="checkbox"/>	<input type="checkbox"/>
Review of systems	<input type="checkbox"/>	<input type="checkbox"/>
Were the following elements described in the physical exam?	Yes	No
Skin	<input type="checkbox"/>	<input type="checkbox"/>
TM's	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Oropharynx	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>

Conclusion:

Fellow's Name	Date	Clinic (Day & AM/PM)
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(Food Allergy Checklist – 03/09/09)

Self Assessment Case Record Checklist –ASTHMA

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

Self-Assessment Case Record Checklist – ANGIOEDEMA/URTICARIA

Angioedema Checklist Not Applicable

Documented (circle)

History elements:

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

Chronic Urticaria checklist Not Applicable

Documented (circle)

History elements:

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

- | | | |
|--|-----------------------|-----------------------|
| 11) Purpuric and/or residual tenderness | <input type="radio"/> | <input type="radio"/> |
| 12) Resolution of lesions without permanent skin changes | <input type="radio"/> | <input type="radio"/> |
| 13) Symptoms (pain, numbness, itching) | <input type="radio"/> | <input type="radio"/> |
| 14) Pt. H/o autoimmune disorders, thyroid disease | <input type="radio"/> | <input type="radio"/> |
| 15) Skin biopsy | <input type="radio"/> | <input type="radio"/> |

Physical Exam Checklist

Documented (circle)
Yes No N.A.

- | | | | |
|---|-----------------------|-----------------------|-----------------------|
| 1) Urticaria characterization; | | | |
| a. size | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. number | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. location | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. linear versus circumferential | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Blanchable | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2) Dermographism present | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3) Palpation for enlarged thyroid, pre-tibial edema, signs of hypo/hyper thyroidism | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Laboratory w/u: if clinically indicated

- | | | | |
|--|-----------------------|-----------------------|-----------------------|
| 1) CBC with differential, LFTs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2) TSH, anti-thyroglobulin and anti-microsomal Abs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3) Lupus package- if photosensitivity, oral ulcers, unexplained fevers and either long-lasting lesions (>>24hr) or nonblanching lesions. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4) SPEP- if angioedematous lesions, fevers/malaise | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Therapies:

- | | | | |
|---|-----------------------|-----------------------|-----------------------|
| • Antihistamines | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • LT antagonists | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Thyroid replacement (if hypothyroid) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Steroids | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| • Immunomodulators (Sulfasalazine, cyclosporine, dapsone, colchicine, Hydroxychloroquine) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Conclusions from review:

Fellow's Name

Date

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Self Assessment Case Record Checklist - RHINOSINUSITIS / CONJUNCTIVITIS

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

Conclusions from review:

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Self Assessment Case Record Checklist – DRUG HYPERSENSITIVITY

<u>History- For each drug reaction, record</u>	Documented (check)		
	YES	NO	NA
1. Reaction description	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
--- Important negatives: pruritis, urticaria, exfoliation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Date (Year) of reaction or time lapse since	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Time from start treatment to onset reaction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Other concomitant medications (list vs. none)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Subsequent treatment with same and/or related drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 Previous evaluations (eg pen STs , rechallenge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Current or projected need for drug	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
 <u>PMH</u>			
	YES	NO	NA
1. Medical conditions now requiring culprit drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Atopic diathesis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Current medications (esp beta blockers, ACE inh.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
 <u>P.E. (assumes post-hoc evaluation)</u>			
	YES	NO	NA
1. Skin: dermatitis, including stigmata of chronic pruritis; necklace-distribution rubor; vasculitic lesions; mucus membrane involvement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
 <u>Lab</u>			
	YES	NO	NA
1. Skin tests where potentially informative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Autoimmune diathesis (cf. urticaria, vasculitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Systemic markers if ongoing (eosinophilia, ESR, tryptase)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Supervised challenge/ desensitization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
 <u>Assessment / Plan</u>			
	YES	NO	NA
1. Clear opinion re: risk of retreatment and/or rank-order likelihood culprits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Recommendation for way forward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Conclusions from review:

Fellow's Name _____

Date _____

Clinic (Day & AM/PM) _____

Reviewed & Accepted: _____

Attending Physician Signature _____

Date _____

Self Assessment Case Record Checklist - Eosinophilic Disorders

Were the following elements addressed in the history?	Documented (check)	
	YES	NO
Onset of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Type of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Organ specificity of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Duration of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Frequency of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Severity of symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Impact of disease	<input type="checkbox"/>	<input type="checkbox"/>
Travel history	<input type="checkbox"/>	<input type="checkbox"/>
Onset of eosinophilia	<input type="checkbox"/>	<input type="checkbox"/>
Magnitude and duration of eosinophilia	<input type="checkbox"/>	<input type="checkbox"/>
Biopsy results or other tests documenting eosinophilic organ system involvement	<input type="checkbox"/>	<input type="checkbox"/>
Other previous diagnostic tests and results	<input type="checkbox"/>	<input type="checkbox"/>
Previous prescription treatment and results including response of eosinophilia to any treatments	<input type="checkbox"/>	<input type="checkbox"/>
Were the following elements described in the physical exam?	YES	NO
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Nasal mucosa/polyps	<input type="checkbox"/>	<input type="checkbox"/>
Oropharynx	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Hepatosplenomegaly	<input type="checkbox"/>	<input type="checkbox"/>
Lymphadenopathy	<input type="checkbox"/>	<input type="checkbox"/>

Self Assessment Case Record Checklist- ATOPIC DERMATITIS

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

Conclusions from review:

Case ID # _____

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Date

03/09/2009