Paul Ogershok, M.D. **Allergy, Asthma, & Immunology**

INITIAL EVALUATION **MEDICAL INFORMATION SHEET**

Patient:_____ DATE:_____ Birthdate:_____ AGE:____

Name of Referring Physician:_____

Do you wish a consultation letter sent to the referring physician? ( )Yes ( )No

Welcome to our medical practice.

Please complete this three page questionnaire in as complete a manner as possible. Feel free to make additional notes in the margins or on Page 4. This information will help Dr. Ogershok during his evaluation and treatment of your medical condition. ***THANK YOU!***

BRIEFLY DESCRIBE YOUR REASON(S) FOR THIS VISIT
(for example, asthma, hay fever, hives etc.):

_____

_____

HOW LONG HAVE YOU BEEN HAVING THESE PROBLEMS?

_____

Doctor's Notes:

SYMPTOMS: Please check all that apply.

NOSE:
( ) Frequent sneezing
( ) Runny nose
( ) Congestion / blockage
( ) Itching
( ) Nose bleeds
( ) Loss of smell
( ) Nasal polyps

SINUSES:
( ) Frequent infections
( ) Pressure in facial bones
( ) Pressure around eyes
( ) Throat drainage
( ) Clearing throat

EARS:
( ) Pain
( ) Itching
( ) Plugging / popping
( ) Loss of hearing

EYES:
( ) Itching / tearing
( ) Burning
( ) Redness
( ) Swelling of eyelids
( ) Dark circles
( ) Infections

LUNGS:
( ) Asthma
( ) Wheezing
( ) Cough-daytime
( ) Cough-nighttime
( ) Productive cough
( ) Dry cough
( ) Wheeze/exercise

GASTOINTESTINAL
( ) Nausea / vomiting
( ) Diarrhea
( ) Constipation
( ) Heart Burn

SKIN:
( ) Contact rash
( ) Eczema
( ) Hives
( ) Itching

HEADACHES:
( ) Sinus
( ) Tension
( ) Migraine

OTHER SYMPTOMS:_____

ASTHMA

Have you been diagnosed with asthma? ( ) Yes ( ) No
Hospitalizations for asthma?_____
School/work days missed? _____
Albuterol use per week? _____

How many years ago? _____
ER visits for asthma? _____
Night awakenings per month? _____
Courses of oral steroids? _____

TRIGGERS OF YOUR SYMPTOMS: Please check all that apply.

When do you have symptoms? ( ) Spring ( ) Summer ( ) Fall ( ) Winter

Which of the following exposures seem to worsen your symptoms?

( ) Yard work	( ) House work	( ) Aerosols	( ) Dry weather	( ) Stress
( ) Mowing lawn	( ) Vacuuming	( ) Perfumes	( ) Wet weather	( ) Foods: (?)
( ) Barns	( ) Exercise	( ) Smoke	( ) Change weather	( ) _____
( ) Cats	( ) Humidity	( ) News print	( ) Cold weather	( ) Latex
( ) Dogs	( ) Other animals	( ) Mold	( ) Aspirin	( ) Bee sting

BIN #1454

CURRENT MEDICATIONS: Please list all medications which are currently being used, either regularly or intermittently.

Medication: Dose / Frequency:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____

Doctor's Notes:

ADVERSE REACTIONS TO MEDICATIONS: Please list all medications to which you have had an adverse reaction, as well as the nature of the reaction:

Medication: Adverse reaction:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

PAST MEDICAL HISTORY: Please list significant medical conditions for which you have seen a doctor in recent years, as well as the form of treatment required.

Medical Condition When? Treatment?

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____
5. _____ _____ _____
6. _____ _____

PREVIOUS ALLERGY EVALUATION & TREATMENT:

Do you have any serious reactions to bee stings? ( ) Yes ( ) No _____
Have you had a previous allergy evaluation? ( ) Yes ( ) No _____
Did you have allergy skin testing? ( ) Yes ( ) No _____
Did you receive immunotherapy (allergy shots)? ( ) Yes ( ) No _____
Did your symptoms improve while on injections? ( ) Yes ( ) No _____
Did you experience any adverse reactions? ( ) Yes ( ) No _____

ENVIRONMENTAL / SOCIAL HISTORY:

Where were you born and raised? _____
How long have you lived in this area? _____
How long have you lived in your present home? _____
How old is your home? _____
What is your occupation? _____
Please check all that apply to your daily environment:
( ) Indoor pets. What pets do you have? _____
( ) Central heat / air conditioning. ( ) Wall-to-wall carpeting
( ) Inner spring mattress ( ) Feather pillow
( ) Upholstered bedroom furniture ( ) In-home air filters
( ) Frequent exposure to smokers ( ) Unusual chemical exposures

SMOKING HISTORY:

( ) Life long non-smoker
( ) Former smoker
How many years? ___
When quit? _____
( ) Current smoker
How many years? ___
Packs/day? _____
( ) Daily exposed tosmoke
( ) Interested in quitting?

BIN #1454A

FAMILY HISTORY: Please check all conditions that occur in your family and indicate who is/was affected.

Medical Condition Who? (for example, father, brother, etc.)

( ) Asthma _____
( ) Eczema _____
( ) Allergies _____
( ) Hives / swelling _____
( ) Headaches _____
( ) Emphysema _____
( ) High blood pressure _____
( ) Cancer _____
( ) Diabetes _____
( ) Insect allergy _____

Doctor's Notes:

IMMUNIZATION HISTORY:

Are your immunizations up-to-date? ( ) Yes ( ) No If you have had any adverse reaction to any routine immunizations, please describe: _____

Last Flu vaccine:_____ Last pneumonia vaccine:_____

BIRTH HISTORY: Term or Premature, Vaginal delivery or C-section_____

REVIEW OF SYSTEMS: Please check any symptoms or diseases that have been a recurrent or chronic problem for you.

( ) Frequent / severe headaches ( ) Eye problems
( ) Fainting / dizziness ( ) Dental problems
( ) Neck injury / disease ( ) Heart disease
( ) Lung disease other than asthma ( ) Stomach / liver disease
( ) Urinary / bladder problems ( ) Bowel difficulties
( ) Orthopedic disease or injury ( ) Skin disorders
( ) Diabetes ( ) Hypertension
( ) Arthritis ( ) Fatigue
( ) Recent weight gain or loss of more than 10 pounds.
( ) Pregnancy or Pregnancy planned
( ) Any severe infections _____

Doctor's Notes:

If there is any additional information that you think would be helpful to Dr. Ogershok, please note this on the next page. Thank you for completing this form. **Please return the clipboard and all papers to the receptionist or nurse.**

Signature of person completing form: _____

FOR OFFICE USE ONLY:

ADMISSION DATA:

VITALS: T:_____ P:_____ R:_____ BP:_____ HT:_____ WT:_____

Remarks: _____

BIN #1454B