JEFFREY S. HALLETT, M.D.

INITIAL EVALUATION **MEDICAL INFORMATION SHEET**

PATIENT NAME:_____ DATE:_____
DATE OF BIRTH:_____ AGE:_____
Name of Referring Physician:_____
Do you wish to have a consultation letter forwarded to the referring physician? [_] Yes [_] No

Welcome to our medical practice.
Please complete this three page questionaire 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. Hallett during his evaluation and treatment of your medical condition. ***THANK YOU!***

I. BRIEFLY DESCRIBE YOUR REASON(S) FOR THIS VISIT
(for example, asthma, hay fever, etc.): _____
_____
HOW LONG HAVE YOU BEEN HAVING THESE PROBLEMS?
_____

*Doctor's Notes:*_____
_____
_____
_____
_____

II. 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

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 with exercise

GASTROINTESTINAL:
[_] Nausea / vomiting
[_] Diarrhea
[_] Constipation
[_] _____

SKIN:
[_] Contact rash
[_] Eczema
[_] Hives
[_] Itching

HEADACHES:
[_] Sinus
[_] Tension
[_] Migraine
[_] Associated with menses
[_] Meds that help:
[_] _____

OTHER SYMPTOMS:_____

III. TRIGGERS OF YOUR SYMPTOMS: Please check all that apply.

During which months do you have symptoms?
[_] JAN [_] FEB [_] MAR [_] APR
[_] MAY [_] JUN [_] JUL [_] AUG
[_] SEP [_] OCT [_] NOV [_] DEC

Which of the following exposures seem to worsen your symptoms?

[_] Yard work
[_] Mowing lawn
[_] Barns
[_] Cats
[_] Dogs
[_] House work
[_] Vacuuming
[_] Exercise
[_] Humidity
[_] Other animals
[_] Aerosols
[_] Perfumes
[_] Smoke
[_] News print
[_] Mold / Mildew
[_] Dry weather
[_] Wet weather
[_] Windy day
[_] Hot weather
[_] Out of doors
[_] Stress
[_] Foods: (which?)
[_] _____
[_] _____
[_] _____

IV. 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._____	_____

V. 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._____	_____

*Doctor's Notes:*_____

VI. 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._____	_____	_____

PREVIOUS ALLERGY EVALUATION & TREATMENT:

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	_____

VII. ENVIRONMENTAL / SOCIAL HISTORY:

Where were you born and raised?_____

How long have you lived in Central Texas?_____

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:

Please check all that apply:

[_] Life-long non-smoker.

[_] Former smoker

How many years?_____

When quit?_____

[_] Current smoker

How many years?_____

How many packs/day?____

[_] Daily exposure to other smokers? _____

[_] Interested in quitting?_____

VIII. 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	_____
[_]	Hay fever	_____
[_]	Hives / swelling	_____
[_]	Headaches	_____
[_]	Emphysema	_____
[_]	High blood pressure	_____
[_]	Cancer	_____
[_]	Diabetes	_____
[_]	Insect allergy	_____

*Doctor's Notes:*_____

IX. IMMUNIZATION HISTORY:

Are your immunizations up-to-date? [_] Yes [_] No. If you have had any adverse reaction to any routine immunization, please describe:_____

X. 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.		

*Doctor's Notes:*_____

If there is any additional information that you think would be helpful to Dr. Hallett, please note this on the next page (Page 4).

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: **DATE:**_____

VITALS: **T:**_____ **P:**_____ **R:**_____ **BP:**_____ **Ht:**_____ **Wt:**_____

Remarks:_____

PATIENT:_____ NO:_____