

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have questions about this notice, please contact our Privacy Officer (Tammy Rather) @ 431-9501 or Privacy Officer assistant –Brandi Martin @ 431-9505

1488 Oak Street Eugene Or 97401

Who will follow this notice?

This notice describes the information privacy practices followed by our physicians, employees and other office personnel.

Your Health Information

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How we may use and disclose health information about you:

We may use and disclose health information about you for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to physicians, medical or office staff from our office or other offices, technicians, hospital staff, or other people who are involved in taking care of you and your health.

For example: Your doctor may be treating you for a medical condition and need to consult with other physicians or technicians about test results. The doctor may need to obtain your medical history from other offices to assist with your treatment. Your doctor may share your health information with another physician to assist that physician with your care.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate care, such as phoning in prescriptions to your pharmacy, scheduling tests at other healthcare facilities, or referring you to a specialist for care.

If you or another entity request that we provide copies of your records and the request is not specific, we will send copies of the past 2 years of clinical notes, tests, reports, and lab reports.

PeaceHealth operates an electronic “community health record” called the “CHR”. This is a computer system that keeps information about you, your health, and the care you receive. We and other providers add health information about you and read what other providers put in. For example, if you had to go to the PeaceHealth emergency room, then the nurse and the physician treating you would be able to find out about your health history, medications you are on, lab results, and other information from PeaceHealth and community physicians to treat your emergency.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at our office may be billed to, and payment may be collected from, an insurance company or other party.

For example: We may give your health insurance company information about why you were seen here so that they will pay us, or reimburse you, for care provided by our office. We may also give information to your health plan so that a service your doctor has recommended may be prior authorized, or we can determine whether or not the service will be paid for by the insurance company. If we are reporting information regarding a work-related or motor vehicle accident injury or problem, we will only send notes regarding the specific problem relating to the injury.

For Health Care Operations: We may use and disclose health information about you in order to run our office and make sure that you and other patients receive quality care.

For example: We may send you an appointment reminder card or call your primary contact number on file with our office, either leaving a message with the person answering or if a message machine is reached we will use this means of communication for reminding you of an upcoming appointment, unless a Restriction Request form has been completed. We may review how your treatment was paid by your insurance company so that we can decide whether to continue providing a specific service. We may tell your health insurance company of a medical condition you have so that they can contact you regarding programs offered that will be beneficial to your care, such as pre-natal or diabetic education programs.

Special Situations: We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To avert a serious threat to health or safety, or a threat to the health and safety of the public or another person.

As required by federal, state or local law.

To military, veterans, national security and intelligence if required by military command or other government authorities.

To worker’s compensation carriers or programs relating to a work injury or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: For audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits or disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner as necessary. For example, to identify a deceased person or to determine the cause of death.

Information not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Call Share Physician Partners: We may disclose health information about you with other physicians or their staff providing call coverage for our office. To the extent that is necessary to ensure quality care.

On Site Research Department: We may use or disclose health information with our on site Research department for possible participation in Clinical Trial studies.

Pharmaceutical Drug assistance program / In-house Special account program- We may use or disclose health and financial information about you with Pharmaceutical companies if you have requested us to help you in your application process and have supplied us with the information. This may include the completion of our In-house “Special” Account form.

Family and Friends: We may disclose health information about you to a family member if you are physically present and ask us to do so. For example, if you bring a family member or friend into an exam room, we will assume your permission to talk to you or that person regarding your health and care needs. We will not disclose your health information to a friend or family member unless you are present and agree to the disclosure. If you desire us to communicate with a friend or family member about your health information in your absence, or to release sample medications or prescriptions we will require written permission from you. However, if a friend or family member brings you to our facility for emergency care and you are unable to communicate, we will keep that person informed of your status and progress. We will also use our professional judgment to make reasonable assumptions about sharing information with that person so that the person can act on your behalf, for example to pick up prescriptions or medical care equipment.

Other Uses and Disclosures of Health Information: We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization to disclose information about you that is not related to treatment, payment or operations. We will require you to fill out our Authorization to Release Information Form, listing specific information you want released and to whom. You may revoke the authorization at any time, in writing, but we cannot take back any uses or disclosures that were already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a specific signed, written Authorization. There is a separate place on our Authorization form to ask for your permission to release this information, and the Authorization will comply with the law governing HIV or substance abuse records.

In accordance with our document retention policy, all inactive records (10 years of non treatment) are destroyed.

Your Rights Regarding Health Information About You: You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and request a copy of your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our Privacy Officer in order to inspect and / or copy your health information. If you request a copy of the information we may charge a fee for the costs of copying, mailing or other associated supplies. *These Payments are payable upon your written request.*

We may deny your request to inspect and receive a copy of your health information in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare provider within our practice to review your request and our denial. The person conducting the review will not be the same person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Records Amendment/Correction Form to our Privacy Officer at the address listed above.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

We did not create, unless the person or entity that created the information is no longer available to make the amendment

Is not part of the health information we keep

You would not be permitted to inspect and copy

Is accurate and complete

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we have made of medical information about you for purposes other than treatment, payment or operations, and not including disclosures for which we have your signed authorization. To obtain this list, you must submit your request in writing to our Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The list will be provided in written format. The first list you request within a 12-month period will be provided at no cost. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. It is our policy that we do not share information about you with family or friends unless you have requested that. However, you additionally have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you by mail instead of by phone. To request confidential communications, you must complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication Form to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice: We are required to give you a copy of this Privacy Policy. By initialing our form in your chart, you are affirming that you did receive a copy. We will give one copy to the head of household in a family and offer a copy to all other family members. A copy of our Privacy Policy is available to any patient upon request.

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. You have a right to request and receive a copy of any revised or changed notices.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer at the address above. **You will not be penalized for filing a complaint.**

Oak Street Medical

Acknowledgment Privacy Policy Offered

Date:

This is an acknowledgement that you have been offered a copy of the Oak Street Medical Privacy Policy, which includes but is not limited to information about the Practices use and disclosure of your Health Information.

***Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and preauthorization).

***Health Care Operations** (includes the necessary administrative and business functions of our office).

We reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Policy** may change also. A summary of the **Policy** will be available in the lobby of our office indicating the revised effective date in the bottom right hand corner. A copy of the **Policy** will be included in each new patient packet. We will offer each existing patient an initial copy of the **Policy** & will provide an additional copy upon request.

I understand that it is my responsibility to read the policy I have been offered and if I have any questions or need clarification I can contact the Privacy Officer Tammy Rather @ 431-9501. or the Privacy Officer Assistant Brandi Martin @ 431-9505.

(Print Patient Full Name)

(Date) _____ (or)
(Signature of patient)

(Date) _____
(Signature of person authorized by law)

AUTHORIZATION TO USE / DISCLOSE / DISCUSS HEALTH INFORMATION

Patient Name:

I authorize Oak Street Medical P.C. to use / disclose / discuss the areas I have identified below with the individuals listed. I acknowledge with the signing of this form the medical data to be released may include information that is specific to HIV/AIDs, drug and or alcohol and / or psychiatric treatment (if I have checked them), which cannot be released without a separate consent.

If you choose to restrict disclosure to anyone please ask for our "Restriction form".

1. _____
Name (Please Print) Relationship (Please Print)

- Unlimited access
- Lab, x-ray, operative & procedure reports, hospitalization reports.
- Alcohol / Drug treatment
- Psychiatric information
- HIV/AIDS information
- Sexually transmitted diseases

2. _____
Name (Please Print) Relationship (Please Print)

- Unlimited access
- Lab, x-ray, operative & procedure reports, hospitalization reports.
- Alcohol / Drug treatment
- Psychiatric information
- HIV/AIDS information
- Sexually transmitted diseases

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

- (1) Creating health information about you to be disclosed to a third party; or
- (2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided you do so in writing. IF you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosure already made with your permission. To revoke this Authorization, please send a written statement to attention of Privacy Officer, Oak Street Medical, 1488 Oak Street, Eugene, OR 97401. The notice should include the full name and relationship of the person you are revoking privileges from, along with your full name, date of birth, current date and signature.

The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law.

This authorization will remain in effect unless a stop date is identified or a written notice to revoke is received.

Stop Date:

Signature

Date

OAK STREET MEDICAL P.C.

Date:

Kraig W. Jacobson, M.D.
Sarah S. Kehl, M.D.
Richard Buck, M.D. / Virginia Buck, M.D.
Jason Friesen, M.D.

1488 Oak Street
Eugene Oregon 97401
Ph: (541) 683-1577
Fax: (541) 344-6176

Thank you for allowing us to become partners in your Health Care!

Enclosed you will find paperwork we need you to complete and bring with you for your appointment. If this is not completed when you come in it may delay your appointment time.

§ If your insurance is a managed care plan, a referral is required from your primary care physician in order to be seen by a specialist. With a managed care plan, please call to make sure the referral has been requested from your primary physician and received by the specialist.

§ As a courtesy, our office will contact your insurance company to confirm co-pay or deductible and benefits. We will call you to inform you of the amount you will need to be prepared to pay to establish your account at your first appointment. Co-payments and Co-insurance are payable at the time of service. We accept cash, checks made payable to Oak Street Medical, Visa or MasterCard.

§ **Late Appointments:** If you are running late for your appointment and have time to call 683-1577 or 431-0000, we would appreciate it, in the event that it may effect your treatment time. (If you are going to be more than 30 minutes late, we will need to reschedule the appointment).

ALLERGY APPOINTMENTS:

§ Please STOP all prescriptions antihistamines 7 days prior to your scheduled appointment. This includes over the counter Claritin. If you are taking over the counter antihistamines such as Benadryl, Tylenol, PM, etc....., these need to be stopped 2 days prior to your scheduled appointment for allergy testing. If you have any questions or concerns, please give our office a call.

Appointment Policy

Our office requires 24 hour notice if an appointment cannot be kept. If you are unable to make your scheduled appointment, please notify us as soon as possible. You can call our main office number between 8am and 5pm. If before 8am or after 5pm, please leave a message on our voice mail. All "No Show" appointments will be documented in the patient's medical record. There is a \$25.00 fee attached to all "No Show" appointments subsequent to the first offense. If the patient has two (2) "No Show" appointments, a letter will be sent to notify the patient that no more appointments will be made in advance. If the patient needs an appointment he/she may call the day they want to come in and see if there is an opening. Continued missed appointments will subject the patient's account for review of possible termination from the Practice.

If you have any questions, please feel free to call the office during regular business hours.
We look forward to meeting you soon.

Warmest regards,

The Office Staff
Oak Street Medical

REGISTRATION FORM
(Use Ink Only)

Oregon Allergy Associates
1488 Oak Street
Eugene Oregon 97401
(541) 683-1577

- Kraig W. Jacobson, M.D.** **Sarah S. Kehl, M.D.**
 Richard Buck, M.D. **Virginia Buck, M.D.**
 Jason H.Friesen, M.D.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Nickname: _____ Maiden Name: _____ Account #: **«PatientNumber»**
Address: _____ City/State/Zip: _____
Home #: _____ Work #: _____ Cell#: _____
Patient Social Security #: ____/____/____ Date of Birth: (mo/d/yr) ____/____/____ Gender: M F

EMPLOYMENT INFORMATION (SCHOOL, IF STUDENT)

Employer / School Name: _____ Occupation: _____ Work Phone: _____
Address: _____ City/State/Zip: _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Social Security #: ____/____/____
Address: _____ City/State/Zip: _____
Home #: _____ Work #: _____ Cell#: _____
Date of Birth: (mo/d/yr) ____/____/____ Relationship to Patient: _____

CONTACT PERSON: RELATIVE OR FRIEND NOT LIVING WITH YOU

Last Name: _____ First Name: _____ Relationship to patient: _____
Home #: _____ Work #: _____ Cell#: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ **AS OF THIS DATE I HAVE NO INSURANCE.**
Address: _____ City/State/Zip: _____
ID#: _____ Group#: _____
Subscriber Name: _____ Subscriber DOB: (mo/d/yr) ____/____/____
Subscriber SS#: ____/____/____ Employer: _____ Eff. Date: ____/____/____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____
Address: _____ City/State/Zip: _____
ID#: _____ Group#: _____
Subscriber Name: _____ Subscriber DOB: (mo/d/yr) ____/____/____
Subscriber SS#: ____/____/____ Employer: _____ Eff. Date: ____/____/____

PRIMARY CARE PHYSICIAN

Primary care physician: _____ Phone #: _____

BUSINESS AND CREDIT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

As a service to our patients, we bill primary and secondary insurance directly. Please understand that insurance coverage is an agreement between you and your insurance company. We will assist in resolving any problems that may arise for payment of your claims but do require you to be the lead advocate in the process.

If you are a new patient to our office; please note that our billing department will call to verify your insurance benefit package prior to your first appointment. We will notify you of the patient portion due at the time of your visit based on your individual policy. Co-payments are due at the time of each visit. Our office accepts both Visa and Master Card for your convenience. We request that the balance be paid within 30 days of your receipt of our statement. If the patient balance is on the account more than 60 days, an interest fee of 18% is applied.

If a Primary Physician referral is required by your insurance policy to see a specialist in our practice, we ask that you ensure ALL (name of referring physician, insurance ID#, & name of employer) information has been provided, and assist in contacting your Primary Physician's office and initiate the process. If you do not have a referral in place and choose to still be seen by one of your physicians, it will require you to sign a waiver and pay at the time services are rendered.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our business office. This will avoid misunderstandings and enable you to keep your account in good standing. Our business office phone number is (541) 683-3401.

A parent or legal guardian must accompany minor patients to all appointments.

I have read, understand, and agree to the above Business and Credit Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to the applicable physician that rendered medical services. I also request payment of government benefits either to myself or to the party who accepts assignment.

Responsible / Insured person, Parent or Guardian

Date

(IF NOT IN THE PRESENCE OF PARENT OR GUARDIAN)

Any Practitioner of Oak Street Medical, P.C.

May unconditionally treat: _____ / _____ / _____
Patient Name Birthdate

in my presence or absence without reservation.

Signature

Relationship

Date

ALLERGY HISTORY FORM

Patient Name:

DOB:

Referring Physician:

Briefly describe reason for visit.					
	Yes	No	(Check each Item)	Onset	Comments
Present Problem	Past Problem				
			<i>Hay fever (itching of nose, sneezing, stuffy nose, runny nose)</i>		
			<i>Asthma (wheezing, cough, shortness of breath, chest tightness)</i>		
			Other Breathing Problems – Shortness of Breath		
			<i>Hives or Swelling (urticaria-angioedema)</i>		
			<i>Sinus Trouble-Infections-decreased sense of smell and taste</i>		
			<i>Eczema or other rashes (poison oak, ect)</i>		
			<i>Food Allergies-Anaphylaxis- shock</i>		
			<i>Frequent or recurrent infections</i>		
			<i>Drug Allergy- Please list the medication(s) and describe symptoms.</i>		
			<i>Bee Sting or Insect Hypersensitivity (Large swelling, hives, shock, or other) Please circle your symptoms.</i>		

SYMPTOMS: Please answer the following: Have you ever had any of the following symptoms? Indicate after the number of days, whether the symptoms were Mild, Moderate or Severe. (if this does not apply to your case, please go on to the next section)

	How many days in the last seven?	Mild Moderate Severe	How many days in an average week in Dec.? <i>Are your symptoms worse in the Winter? Yes / No</i>	Mild Moderate Severe	How many days in an average week in June? <i>Are your symptoms worse in the Spring (May/June)? Yes / No</i>	Mild Moderate Severe
<i>Sneezing</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Nasal Congestion or Runny Nose</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Itching Nose</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Itching Eyes</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Coughing</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Wheezing</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Coughing or Wheezing with Exercise</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Headaches</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

GEOGRAPHIC HISTORY: Please list your last residence (City & State only) **City:** _____ **State:** _____

	Condition Made Worse	Condition Improved	No Change	Does Not Apply		Condition Made Worse	Condition Improved	No Change	Does Not Apply
<i>Mowing lawn, walking on grass or playing in grass</i>					<i>Trips away from home. (Specify area and time of year) _____</i>				
<i>High winds, or riding in auto with windows open, air conditioning</i>									
<i>Sweeping, dusting, using vacuum cleaner</i>					<i>Smoking or smoke exposure</i>				
<i>Moldy or mildewed areas or articles. Exposure to mold or mildew.</i>					<i>Emotional upsets</i>				
<i>Contact with animals- (Specify) _____</i>					<i>Heavy physical exertion or exercise</i>				
<i>Strong odors; ex household cleaners, paints, perfumes</i>									

Are you up to date on your immunizations? Yes No Not Sure

Have you ever noticed any symptoms (hives, swelling, asthma, stomach ache, vomiting or diarrhea) after any of the following foods.

(Check appropriate boxes)

Milk Eggs Wheat Fish Shell Fish Peanuts Other Nuts Soy Other foods (List) _____

Explain:

Have you ever had allergy skin tests? Yes No *If yes, approximate year(s)* _____ *Doctor's Name/location:* _____

Do you recall the results of these tests? (If so, please list the positive tests) _____

Did you ever receive allergy injections? Yes No *If yes, approximate years:* _____

Please list all medication that you are now taking:

What other medications have you taken in the past for allergies?

Have you ever had any of the following? (Please check at left of each item)

Yes	No	(Check each item)	Yes	No	(Check each item)	Yes	No	(Check each item)
		Colic or Spitting up as an infant			Heart Trouble			Tonsils or adenoids Removed (Date)
		Ear Infections (Dates)			High Blood Pressure			Operation on Nose or Sinuses
		Pneumonia (Dates)			Kidney Trouble			Chest x-ray or CT (Date)
		Frequent Headaches			Liver Trouble			Sinus x-ray or CT (Date)
		Frequent Nose Bleeds			Tuberculosis			
		Anosmia (difficulty with sense of smell)			Glaucoma			

HOSPITALIZATIONS: (Please list)

Cause: _____ Date _____

Cause: _____ Date _____

OPERATIONS: (Please list)

_____ Type _____ Date _____

_____ Type _____ Date _____

FAMILY HISTORY:

Is there a history of allergy in your family? (i.e. parents, grandparents, brothers or sisters, children, aunts or uncles)

Yes No *If yes, List. Relationship*

Allergies	
Eczema	
Asthma	
Recurrent Infections	
Hives	

ENVIRONMENTAL & SOCIAL HISTORY:

What type of work do you do?

Are you exposed to anything at work that might aggravate your condition?

Have you missed any time from work or school because of allergies? How much time?

Do you have any other unusual exposures from hobbies or etc.?

<i>Where do you live? (Area of city or country)</i>	<i>How old is your house?</i> _____
	<i>Does your house have dampness, water leaks, mold or mildew problems? (Circle)</i>
<i>Type of heating (Forced hot air, hot water, steam, space heater, baseboard, electric ceiling, heat pump, wood stove, pellet stove)</i>	<i>Do you have air conditioning?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Do you have an air cleaner?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Is your bedroom carpeted?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No / <i>Do you have hard surface flooring?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Are your mattress and pillow encased?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Does your bedroom or house tend to be dusty?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Is your pillow stuffed with feathers?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Is your mattress:</i> <input type="checkbox"/> Foam rubber <input type="checkbox"/> Innerspring & Cotton <input type="checkbox"/> Cotton <input type="checkbox"/> Waterbed <input type="checkbox"/> Other (specify) _____
<i>Do you have feather comforters?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Do you have pets?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please list number</i> <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Birds <input type="checkbox"/> Other (Specify) _____	<i>If yes, do they come inside?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No / <i>Where do they sleep?</i> _____
<i>Have you ever noted symptoms after exposure to them? Explain.</i>	

Have you ever smoked? **Yes** **No** / Do you presently smoke? **Yes** **No** / What? (Cigarette, cigars, pipe?) _____
How many years have you smoked or did you smoke? /Average per day at your highest point? / When did you quit?