WARREN W. PLESKOW, M.D.
Asthma, Allergy & Internal Medicine
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Encinitas, California 92024
Telephone: (760) 436-3988

Date _____

REGISTRATION INFORMATION

PLEASE PRINT

PATIENT INFORMATION

Patient: _____
Last Name First Initial

Address: _____
Street City State Zip

Driver's License Number: _____

Home Phone: _____ Social Security No.: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Cell Phone: _____ Best number to reach you during the day: _____

EMPLOYMENT INFORMATION

Patient Employed By: _____

Business Address: _____
Street City State Zip

Business Phone Number: _____ Occupation: _____

SPOUSE OR PARENT INFO

Spouse (or Parent if Minor) Name: _____ Social Security No.: _____

Employed By: _____ Occupation: _____

Business Address: _____
Street City State Zip

BILLING INFORAMTION

Who is responsible for this account? _____ Relationship to Patient: _____

Do you have medical insurance? ☐ Yes ☐ No If YES: _____

Name of Primary Insurance Co.: _____

Subscriber's Name: _____

Subscriber's Birthdate: _____ Group# _____ Subscriber # _____

Deductible: _____ Has Deductible Been Met? _____ Co-Pay: _____

Name of Secondary Insurance (if any): _____

Contract # _____ Group # _____ Subscriber # _____

I prefer to: ☐ Pay my balance in full at the time of service. ☐ Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified? _____ Phone: _____

Purpose of this visit: _____

How did you learn of our Practice: _____

I hereby authorize Dr. Warren Pleskow to furnish to the above insurance company(s) or to a designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to Dr. Warren Pleskow all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the even of non-repayment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

_____ _____
Insurer or Guardian Signature Patient's Signature

Warren W. Pleskow, M.D.

MEDICAL HISTORY

Name _____ **Age** _____ **Date** _____

Nature of Complaint _____

List All Hospitalizations and Surgeries (give approximate dates)

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

Current Medications/Dosages (include hormones, aspirin, over-the-counter drugs)

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

Drug Allergies

1 _____ 3 _____ 5 _____

2 _____ 4 _____ 6 _____

Smoking History (please circle): Current Past Never

If smoker, how much? _____

Describe Family History of Illness/Disease:

_____

_____

_____

Medical Problems, Current or Past (please check):

____ hayfever	____ tuberculosis	____ epilepsy
____ asthma	____ peptic ulcer	____ stroke
____ food allergies	____ abdominal pain	____ migraine headaches
____ diabetes	____ heartburn	____ other headaches
____ thyroid disease	____ colitis	____ dizziness/vertigo
____ arthritis	____ liver disease	____ cataracts
____ high blood pressure	____ hepatitis	____ glaucoma
____ heart disease	____ hemorrhoids	____ wear glasses/contacts
____ heart attack	____ constipation	____ wear hearing aid
____ mitral valve prolapse	____ diarrhea	____ wear dentures
____ heart failure	____ gall stones	____ anxiety or depression
____ angina	____ urinary disorder	____ alcohol or drug addiction
____ swelling of feet/ankles	____ kidney disease/stones	____ musculoskeletal disorder
____ shortness of breath	____ prostate disorder	____ rheumatic fever
____ pneumonia	____ anemia	____ skin disorder
____ emphysema	____ leukemia	____ hormonal disease
____ chronic bronchitis	____ cancer	____ Gyn (female) problems

Please List Any OTHER Significant Medical Problems/Illnesses:

_____

_____

_____

_____

Warren W. Pleskow, M.D.

ALLERGY QUESTIONNAIRE

Name _____ Date _____

1. Check the following allergic problems you have:

___ hayfever (allergic rhinitis)
___ eye problems
___ asthma/lung or breathing problems
___ food allergy
___ insect allergy
___ nasal or sinus condition
___ ear problems
___ eczema/hives or skin problems
___ drug allergy
___ headaches

2. List all cities in which you have lived (in order): _____

3. Have you ever seen an allergist or had allergy testing? ____Yes ____No
(If yes, give dates and results): _____

4. Have you ever been on allergy shots? ____Yes ____No

5. Do you have a family history of allergy? ____Yes ____No
(If yes, please explain): _____

6. Do you smoke? ____Yes ____No
Have you ever smoked? ____Yes ____No

7. Check the following items which are found in your home or environment:

___ cigarette smoke
___ dust
___ mold
___ water damage to home
___ feather pillow
___ air purifier
___ dogs
___ cats
___ horses
___ birds
___ other pets/animals
___ bedroom carpeting
___ boxspring
___ waterbed
___ forced air heating
___ air conditioning
___ humidifier
___ mattress encasing

8. Check if you have had:

___ tonsils removed
___ adenoids removed
___ nasal or sinus surgery
___ tubes in ears
___ chest or lung surgery
___ sinus infections
___ deviated septum
___ croup
___ aspirin allergy
___ wine or alcohol allergy

9. List all current and past medications for allergy/asthma (including inhalers and nasal sprays):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Complete this section if you have HAY FEVER/NASAL OR SINUS PROBLEMS

Symptoms (please check)

____ sneezing	____ clear drainage	____ frequent ear infections
____ itchy eyes	____ thick drainage	____ frequent sore throats
____ itchy nose	____ yellow or green drainage	____ cough or wheeze
____ nasal congestion	____ sinus pain	____ poor sense of smell
____ postnasal drip	____ headaches	____ poor sense of taste
____ runny nose	____ swollen glands	____ nosebleeds

Age when symptoms were first noted:_____

Occurrence of symptoms:

____ year-round ____ year-round but especially bad at certain time/season
____ seasonal ____ vary with weather conditions ____ vary with location
____ caused by allergens (pollens, dust, animals, etc.)

Have you ever had nasal polyps? ____ Yes ____ No

Have you ever had nasal or sinus surgery? ____ Yes ____ No

Have you ever had sinus x-rays? ____ Yes ____ No
If yes, were they: _____ normal _____ abnormal

Have you ever had tubes in your ears? ____ Yes ____ No

Complete this section ONLY if you have ASTHMA/LUNG OR BREATHING PROBLEMS

Symptoms: (please check)

____ wheezing	____ cough	____ shortness of breath
____ chest tightness	____ night cough	____ clear mucus
____ chest congestion	____ cough/wheeze with exercise	____ yellow or green mucus

Age when symptoms were first noted:_____

How often do you have these symptoms:

____ daily ____ once or twice a week ____ once or twice a month
____ only occasionally ____ only with exercise ____ only with infections
____ only certain seasons/time of year

Have you ever been hospitalized for this problem? ____ Yes ____ No

Have you ever been to an emergency room for this problem? ____ Yes ____ No

Have you ever taken prednisone/cortisone/steroids for this problem? ____ Yes ____ No

Check those things which may worsen your symptoms:

____ exercise	____ Santa Ana conditions	____ hormonal changes
____ change of seasons	____ rain	____ emotions
____ alcohol	____ smog	____ others (please list):
____ aspirin	____ fog	_____
____ cigarette smoke	____ respiratory infections (colds)	_____
____ other drugs	____ allergies (pollens, dust, animals, etc.)	_____
____ foods	____ food preservatives (sulfites, MSG, etc.)	_____

Additional comments:_____