Dr. Daniel Cameron and Associates

Daniel J. Cameron, M.D., M.P.H., P.C
657 Main Street, Mt. Kisco, NY 10549
Phone: 914-666-4665 Fax: 914-666-6271
Email: info@danielcameronmd.com

NAME: Date:

Please provide the following:

1. Tick-borne history: Is there is a history of exposure to ticks? □ YES □ NO

□ If yes, check box below:

- The State you currently live in or previous residence
- The State you currently work in or previous state you work at
- Recreation area, state(s)
- Vacationing in what state
- Pets:
  □ Cats □ Dogs □ Horses □ Other
- Hiking
- Camping
- Playing sports
- Hunting
- Fishing
- Other
- Gardening

2. Is there a history of a tick bite(s)? □ YES □ NO

□ If yes, check the box and provide details below

- Was it a deer tick?
- Was it another type of tick? If so, what did it look like
- Tick bite:
  Engorged Not engorged
- How long was the tick attached?
  - Present less than 24 hours
  - Present 24 to 48 hours
  - Present 48 to 72 hours
  - Present more than 72 hours
- Where on your body was the tick located:
- Was it removed by medical professional?
  YES NO
- What was the date of the tick bite(s)?

3. Is there a history of a rash? □ YES □ NO

□ If yes, check and provide details below:

- Rash description:
  - Circular
  - Oval
  - Round
  - Bulls eye
  - Flat
  - Raised
  - Less than 2 inches in diameter
  - Over 2 inches in diameter
  - Itchy
  - Not itchy
  - Purple
  - Date of the rash
- Where on your body was the rash located? Please specify:

4. Initial Tick-borne history: Please provide <u>Timeline</u> (including date) of your history of your illness: *See word document attached to type in your full history*

5. Initial function: The initial functional limitations include:

- ☐ maintaining personal hygiene and grooming
- ☐ maintaining socially appropriate
- ☐ making simple decisions
- ☐ working
- ☐ working at a consistent pace
- ☐ walking
- ☐ understanding and remembering instructions
- ☐ sitting
- ☐ standing
- ☐ attending school
- ☐ participating in school
- ☐ maintaining grades
- ☐ attending GYM
- ☐ carrying more than 10 pounds
- ☐ stooping
- ☐ crawling
- ☐ repetitive finger movement
- ☐ word finding
- ☐ completing tasks
- ☐ difficulties functioning as a spouse
- ☐ difficulties functioning as parent
- ☐ walking, required a cane
- ☐ walking, required a wheelchair
- ☐ driving

6. Have there been any obstacles in your Lyme disease treatment? If yes, check below:

- ☐ diet of simple sugars
- ☐ evidence of co-infections
- ☐ inactivity
- ☐ pain
- ☐ problems at school
- ☐ problems at work
- ☐ psychiatric problems
- ☐ relationship problems
- ☐ sleep issues
- ☐ substance use
- ☐ steroid use
- ☐ treatment delays

7. Did you have a positive/abnormal tests for Lyme disease or a tick borne illnesses? If yes, check below:

- ☐ Lyme Western blot IgG
- ☐ Lyme Western blot IgM
- ☐ Babesia
- ☐ Ehrlichia
- ☐ Anaplasmosis
- ☐ Bartonella
- ☐ MRI
- ☐ CT
- ☐ EMG
- ☐ NCV
- ☐ Spinal tap
- ☐ SPECT
- ☐ PCR
- ☐ EEG
- ☐ X rays
- ☐ Thyroid
- ☐ Rheumatoid arthritis
- ☐ Sed rate
- ☐ Other

8. Were you evaluated by any other physicians during this illness? If yes, check the box below:

- ☐ Allergist – Name:
- ☐ Cardiologist – Name:
- ☐ Chiropractor – Name:
- ☐ Complementary Medicine – Name:
- ☐ Emergency room – Name:
- ☐ Endocrinologist – Name:
- ☐ ENT – Name:
- ☐ Gastroenterologist – Name:
- ☐ Gynecologist – Name:
- ☐ Hospital – Name:
- ☐ Infectious disease physician – Name:
- ☐ Neurologist – Name:
- ☐ Neurosurgeon – Name:
- ☐ Pediatrician
- ☐ Primary care physician – Name:
- ☐ Rheumatologist – Name:
- ☐ Ophthalmologist – Name:
- ☐ Orthopedic surgeon – Name:
- ☐ Otolaryngologist
- ☐ Pain management – Name:
- ☐ Podiatrist – Name:
- ☐ Psychiatrist – Name:
- ☐ Surgeon – Name:
- ☐ Urgent Care Center – Name:
- ☐ Urologist – Name:
- ☐ Vascular surgeon – Name:
- ☐ Physiatrist (Physical Medicine and Rehabilitation) – Name:

9. Antibiotic treatment: The treatment summary includes treatment number, date of treatment, medication, outcome and/or comments:

Treatment 1:

Treatment 2:

Treatment 3:

10. Tick borne illnesses based on: one of the following additional findings described by the CDC? If yes, check below:

☐ Bell's palsy ☐ Meningitis ☐ Heart block ☐ Arthritis

11. Do you have any other symptoms not discussed on Review of Symptoms Scale (ROSS)? If yes, check below:

□ Appetite loss	□ Shortness of breath	□ Swelling in hands/feet
□ Weight gain	□ Cough	□ Changes in skin color/hair/nails
□ Vision loss	□ Heartburn	□ Poor Balance
□ Light sensitivity	□ Vomiting	□ Anxiety
□ Double vision	□ Excessive gas	□ Difficulty Speaking
□ Eye redness	□ Bloating	□ Thoughts of suicide/violence
□ Eye swelling	□ Constipation	□ Muscle weakness
□ Eye discharge	□ Inability to control bladder	□ Muscle cramp
□ Earache	□ Frequent Urination	□ Rash
□ Decreased hearing	□ Burning when urinating	□ Itching
□ Nasal congestion	□ Blood in urine	□ Heat/Cold Intolerance
□ Hoarseness	□ Tremors/Seizures	□ Difficulty breathing
□ Irregular Menstrual Cycle		□ Other