ASTHMA
TREATING PHYSICIAN
DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PHYSICIAN'S NAME AND ADDRESS

PHYSICIAN'S TELEPHONE

PHYSICIAN'S EMAIL

PATIENT'S NAME AND ADDRESS

PATIENT'S TELEPHONE

PATIENT'S EMAIL

PATIENT'S SSN

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB
Title 16 ☐ DI ☐ DC

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐
Initial CDR ☐ Hearing Officer ☐
Administrative Law Judge ☐ Appeals Council ☐
Federal District Court ☐ Federal Appeals Court ☐

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical specialty please:

Note 1: This document will not have legal validity for Social Security disability determination purposes unless completed by a licensed medical doctor or osteopath.

Note 2: This document only concerns asthma. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

Copyright David A. Morton III, M.D.

I. Please provide the date of diagnosis of asthma.

Date of diagnosis:

II. Please also complete Form 3.02. The information needed on this form is important, but only supplemental to Form 3.02.

III. Have there been asthmatic attacks requiring physician intervention in the past year?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please answer the following questions.

A. Does the person currently smoke?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, have you prescribed smoking cessation?

☐ **Yes** ☐ **No** ☐ **Unknown**

B. Please specify the following for the past year:

Total number of asthma attacks treated, including ER:

Total number of intensive inpatient treatments lasting over 24 hours:

Number of inpatient treatments requiring prolonged inhaled bronchodilators:

Number of inpatient treatments requiring intravenous bronchodilators:

Number of inpatient treatments requiring antibiotics:

Other intensive inpatient treatment for asthma:

IV. Which of the following medications is required on a regular basis?

Inhaled bronchodilators	☐ **Yes**	☐ **No**	☐ **Unknown**
Oxygen	☐ **Yes**	☐ **No**	☐ **Unknown**
Antibiotics	☐ **Yes**	☐ **No**	☐ **Unknown**
Short-acting beta2-agonists	☐ **Yes**	☐ **No**	☐ **Unknown**
Long-acting beta2-agonists	☐ **Yes**	☐ **No**	☐ **Unknown**
Corticosteroids	☐ **Yes**	☐ **No**	☐ **Unknown**
Methylxanthines	☐ **Yes**	☐ **No**	☐ **Unknown**
Cromolyn sodium or Nedocromil	☐ **Yes**	☐ **No**	☐ **Unknown**
Leukotriene modifiers	☐ **Yes**	☐ **No**	☐ **Unknown**

Has the patient missed prescribed medication doses?

☐ **Yes** ☐ **No** ☐ **Unknown**

Copyright David A. Morton III, M.D.

If so, what and why?

V. Does the patient have exercise-induced asthma?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, have you observed the patient have exercise-induced asthma (e.g., on a cardiac stress test).

☐ **Yes** ☐ **No** ☐ **Unknown**

Please explain circumstances and exercise level at symptom onset.

VI. Does the patient monitor their condition with a peak flow meter?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes,** which values for peak expiratory flow (PEF) in your records best represent the patient's condition in general, when complaint with medications, not smoking, and not suffering acute pulmonary infection?

PEF above 80% of normal ☐
PEF 50 – 80% of normal ☐
PEF below 50% of normal ☐

VII. Are you aware of any environmental antigens or other factors that trigger an asthmatic attack?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please explain.

Copyright David A. Morton III, M.D.

VIII. Please complete Form 3.02 for treatment, functional severity, or other issues.

____
Physician's Name (print or type)

____
Physician's Signature (no name stamps)

____
Date

Copyright David A. Morton III, M.D.