

New Patient Registration



**Pulmonary & Critical Care
Medicine Associates**

Expertise, Compassion, Results

Personal Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender (Please Check One): Male Female

Marital Status (Please One): Married Divorced Widowed Single

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Referring Physician: _____ Family Physician: _____

Other Specialists: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Local Pharmacy _____ Mail Order Pharmacy _____

Do you have a medical supply company (DME)? _____ If yes, who? _____

If yes, for what? Oxygen Nebulizer Machine CPAP/BiPAP Ventilator

New Patient Questionnaire

What brings you to our office today? _____

How long have you had this problem? _____

Have you seen a lung or sleep specialist in the past? _____ If yes, who? _____

Please check if you have had any of these tests done, please list where and when they were done.

Pulmonary Function Test (Breathing tests): _____

Chest X-Rays: _____

CT Scan of Chest: _____

Echocardiogram: _____

Sleep Studies: _____

Patient's First and Last Name: _____ Date of Birth: _____

Past Medical History

Do you have any of the following health problems?

- | | | |
|---|--|---|
| <input type="checkbox"/> COPD | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Asbestosis |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> DVT (Blood Clots in Legs) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Other Medical Conditions _____ | | |

Allergies to Medications

Any allergies to medications? Yes No

If yes, please list: _____

Surgical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Lung Surgery | <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> CABG (Bypass Surgery) |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Pacemaker/ICD Placement | <input type="checkbox"/> Tonsils and Adenoids |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy (Gallbladder) | <input type="checkbox"/> Nasal Surgery |
| <input type="checkbox"/> Weight Loss Surgery | <input type="checkbox"/> Cataract Surgery | |
| <input type="checkbox"/> Other surgeries- Please list: _____ | | |

Please list any hospital admission in the past 5 years. _____

Patient's First and Last Name: _____ Date of Birth: _____

Family History

List which relative (father, mother, or siblings) has any of the following conditions:

Lung Cancer	_____	Hypertension	_____
Emphysema	_____	Heart Disease	_____
Sleep Apnea	_____	Stroke	_____
Diabetes	_____	DVT/PE	_____
Narcolepsy	_____	Cancer	_____

Social History

Do you smoke or have you ever smoked? Never Current Former

If current or former smoker, how many years have you smoked? _____

If former smoker what year did you quit? _____

Do you drink alcohol? Yes No If yes, how often? _____

Do you use any recreational drugs? Yes No

If yes, which drugs? _____

Do you drink any caffeine? Yes No How many cups per day? _____

What is or was your occupation? _____

Have you had any prolonged exposure to the following?

- | | | |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Dust | <input type="checkbox"/> Fumes |
| <input type="checkbox"/> Cleaning Chemicals | <input type="checkbox"/> Steel Dust | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bird Exposure | | |

Please list any animals/pets you have had? _____

Vaccines

Have you received any of the following vaccines?

Pneumococcal 23 Yes No When? _____

Pevnar 13 Yes No When? _____

Flu Yes No When? _____

Patient's First and Last Name: _____ Date of Birth: _____

Medications

Please write or provide a list of ALL medications you are currently taking, including prescription, over-the-counter, vitamins, and inhalers.

	Medications	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Review of Systems

General	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Night sweats
Sleep	<input type="checkbox"/> Daytime fatigue	<input type="checkbox"/> Snoring	<input type="checkbox"/> Restless legs	<input type="checkbox"/> Non-refreshing Sleep	<input type="checkbox"/> Insomnia
ENT	<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Dry Mouth
Respiratory	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Sputum Production
Cardiovascular	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Irregular Heartbeat
Gastrointestinal	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Reflux/Heartburn/Indigestion	<input type="checkbox"/> Blood in Stool
Genitourinary	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequent Night time Urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Blood in Urine
Hematology	<input type="checkbox"/> Lymph Gland Swelling	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Cancer	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Anemia

Patient's First and Last Name: _____ Date of Birth: _____

STOP-BANG Questionnaire

- | | | |
|---|-----|----|
| 1. S noring- Do you snore loudly
(loud enough to be heard through closed)? | YES | NO |
| 2. T ired- Do you often feel tired, fatigued, or
sleepy during the daytime? | YES | NO |
| 3. O bserved Breathing Patterns- Has anyone
observed you stop breathing during sleep? | YES | NO |
| 4. B lood P ressure- Are you being treated for
high blood pressure? | YES | NO |
| 5. B MI- Body Mass Index more that 35kg/m ² ? | YES | NO |
| 6. A ge- Are you over 50 years old? | YES | NO |
| 7. N eck Circumference- Is your neck size
greater than 17" for men and 16" for women? | YES | NO |
| 8. G ender- Are you male? | YES | NO |

Total YES Score _____

Epworth Sleepiness Scale

- | | Scoring
Model |
|--|------------------|
| 1. Chance of dozing sitting and reading? | _____ |
| 2. Chance of dozing watching TV? | _____ |
| 3. Chance of dozing in an inactive public place?
(i.e. movie theater, waiting room, meeting)? | _____ |
| 4. Chance of dozing as a passenger in car for an
hour without a break? | _____ |
| 5. Chance of dozing if you lie down to rest in the
afternoon. | _____ |
| 6. Chance of dozing sitting and talking with someone? | _____ |
| 7. Chance of dozing sitting quietly after lunch? | _____ |
| 8. Chance of dozing while the car is stopped?
(i.e. traffic or red light) | _____ |
| Total | _____ |

Please Use This Scale:

- 0- No Chance
- 1- Slight Chance
- 2- Moderate Chance
- 3- High Chance

Patient's First and Last Name: _____ Date of Birth: _____

Sleep Evaluation Patients Only

- I have been told I snore.
- I have been told I stop breathing when I sleep.
- I have high blood pressure.
- I have fallen asleep when I am driving.
- I get morning headaches.
- I suddenly wake up gasping of breath.
- I notice heart beating or pounding irregularly during the night.
- I am overweight.
- I often have difficulty falling asleep.
- I frequently wake with dry mouth.
- Thoughts race through my mind and prevent me from sleeping.
- I wake up earlier than I would like.
- I often feel like I am in a daze.
- I have experienced vivid like dreams.
- I have trouble at work because of sleepiness.
- I have fallen asleep in social setting like a party or movie.
- I have "sleep attacks" during the day no matter how hard I try to stay awake.
- I have episodes of feeling paralyzed during sleep or when awake.
- I have been told parts of my body jerk when I am asleep.
- I experience an aching or crawling sensation in my legs at night.
- Even though I slept during the night, I am sleepy during the day.
- I dream soon after I fall asleep or during naps

Signature

Signature of Patient or Authorized Representative

Relationship to Patient

Signature of Practice Representative

Title