Name:_____ Date of Visit: _____

New Patient Form

Reason for Visit:

□ Abnormal Chest X-Ray	□ Chest Congestion	□ Fatigue	□ Pulmonary Hypertension
□ ABPA	□ Chest Pain	□ Hemoptysis	□ Rhinitis
□ Asthma	□ Chronic Cough	□ Hypoxia	□ Shortness of Breath
□ Asbestosis (Expose to Asbestos)	□ COPD	□ Lung Mass/Cancer (circle)	□ Pneumonia Type _____
□ Bronchitis	□ Cystic Fibrosis	□ Nose Bleed	□ Sleep Apnea
□ Carcinoid	□ Emphysema	□ Occupational Lung Disease	□ Snoring
□ Cataplexy	□ Emphysematous Bleb	□ Pleural Effusion	□ Tuberculosis
□ Hypertension	□ Hyperlipidemia	□ Gastroesophogeal Reflux	□ Smoking Cessation
□ Depression	□ Restless Leg Syndrome	□ Sarcoidosis	□ Pleurisy

Condition(s) Not Presented:

_____

Is this a Follow Up After: □ Hospitalization □ Lab Test □ Diagnostic Procedure (X-Ray, CT Can, etc)

Is this a Pre-Op Visit? □ Yes □ No If yes what procedure? _____

Past Medical History:

□ Abnormal Chest X-Ray	□ Chest Congestion	□ Hypothyroidism	□ Pneumonia Type _____
□ ABPA	□ Chest Pain	□ Hypertrophy of Prostate (Enlarged)	□ Positive Skin Test for Tuberculosis
□ Asthma	□ Chronic Cough	□ Hypoxia	□ Restless Leg Syndrome
□ Asbestosis (Expose to Asbestos)	□ Depression	□ Irritable Bowel Syndrome	□ Rhinitis
□ Anxiety	□ Diabetes	□ Interstial Lung Disease	□ Sarcoidosis
□ Arthritis-Rheumatoid	□ Embolism-Pulmonary	□ Lung Mass/Cancer (circle)	□ Seizure Disorder
□ Atherosclerosis	□ Emphysema	□ Multiple Sclerosis	□ Shortness of Breath
□ Bronchitis (Acute)	□ Emphysematous Bleb	□ Nyocardial Infarction	□ Sinusitus
□ Bronchiectasis	□ Fatigue	□ Nose Bleed	□ Smoking Cessation
□ Carcinoid (Cancer)	□ Gastroesophogeal Reflux	□ Occupational LungDisease	□ Snoring
□ Cardiomyopathy	□ Hepatitis	□ Obesity	□ Sleep Apnea-Central
□ Cataplexy	□ Hiatal Hernia	□ Osteoporosis	□ Sleep Apnea-Obstructive
□ Congestive Heart Failure	□ Hypertension	□ Pulmonday Hypertension	□ Insomnia
□ COPD (Chronic Bronchitis)	□ Hemoptysis	□ Pleurisy	□ Narcolepsy
□ Cystic Fibrosis	□ Hyperlipidemia	□ Pleural Effusion	□ Tuberculosis

Name:_____ Date of Visit: _____

Allergy History:

□ No Known Allergies □ No Known Drug Allergies □ Allergy History Unknown
□ Have had an "Allergic Reaction", but do not know cause? Reaction Experienced: _____

Medication Allergies:

□ ACE Inhibitors	Reaction:_____	□ Acetaminophen	Reaction:_____
□ Aminoglycosides	Reaction:_____	□ Aspirin (Salicylates)	Reaction:_____
□ Barbiturates	Reaction:_____	□ Benzodiazepines	Reaction:_____
□ Cephalosporin	Reaction:_____	□ Codeine (Derivatives)	Reaction:_____
□ Erythromycins	Reaction:_____	□ Morphine (Derivatives)	Reaction:_____
□ Iodine (Contrast)	Reaction:_____	□ Anesthetics	Reaction:_____
□ Penicillin	Reaction:_____	□ Zithromax	Reaction:_____
□ Other: _____	Reaction:_____	□ Other: _____	Reaction:_____
□ Other: _____	Reaction:_____	□ Other: _____	Reaction:_____

Food Allergies:

□ Food:_____	Reaction:_____	□ Food:_____	Reaction:_____
□ Food:_____	Reaction:_____	□ Food:_____	Reaction:_____
□ Food:_____	Reaction:_____	□ Food:_____	Reaction:_____

Environmental:

□Mold	Reaction:_____	□ Pollen	Reaction:_____
□Dust	Reaction:_____	□ Insect Bite(_____)	Reaction:_____
□ Other: _____	Reaction:_____	□ Other: _____	Reaction:_____
□ Other: _____	Reaction:_____	□ Other: _____	Reaction:_____

Family History:

□ **No known Pertinent**	Family History		
□ **Apnea**	Family Member:_____	□ **Asthma**	Family Member:_____
□ Bleeding Disorder	Family Member:_____	□ **Cancer**: _____	Family Member:_____
□ CHF	Family Member:_____	□ **Coronary Heart Disease**	Family Member:_____
□ CVA	Family Member:_____	□ Depression	Family Member:_____
□ **Diabetes**	Family Member:_____	□ Emphysema	Family Member:_____
□ Goiter	Family Member:_____	□ **Heart Disease**	Family Member:_____
□ Hypercholesterolemia	Family Member:_____	□ **Hypertension**	Family Member:_____
□ Insomnia	Family Member:_____	□ Kidney Disease	Family Member:_____
□ Myocardial Infarction	Family Member:_____	□ Narcolepsy	Family Member:_____
□ **Pulmonary Fibrosis**	Family Member:_____	□ Respiratory Condition	Family Member:_____
□ Restless Leg Syndrome	Family Member:_____	□ Seizure disorder	Family Member:_____
□ Suicide	Family Member:_____	□ Thyroid problems	Family Member:_____
□ TIA	Family Member:_____	□ Tuberculosis	Family Member:_____

Name:_____ Date of Visit: _____

Social History:

Are you at risk for HIV? □ Yes □ No

If yes, what are your risk factors?

□ Unprotected Sex	□ Injection Drug User	□ Occupation
□ Caregiver of HIV Pos. Individual(s)	□ Transfusion Recipient	□ Other: _____

Are you currently employed? □ Yes □ No

□ Disabled □ Disabled due to HIV □ Disabled due to non-HIV condition □ Full Time

□ Part Time □ Retired □ Self Employed □ Unemployed Looking for Work

□ Unemployed not looking for work □ Other

Primary Occupation? _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Do you Exercise: ___Yes ____ Hours Day _____ Day(s) Weekly ___No Exercise Daily

Sleeping Habits: _____ Hours Nightly on Average

Alcohol Use:

□ Do Not Drink	□ Occasional Use (1-8 beverages x monthly)	□ Moderate Use (2-10 beverages weekly)	□ Heavy Use (6+ beverages daily)
□ Quit Drinking (When?)	Date: _____		

Tobacco Use:

□ Never Smoked	□ Smoke (___ pks daily)	□ Smoke (non-cigarette) Type: _____	□ Chewing Tobacco
□ Quit Smoking	When did you quit? Date: _____	How many years previously smoked? ____	When you did smoke, how many pks daily? _____

Drug Use:

□ No Drug Use □ Quit Drug Use (When?) Date: _____

Drug Used? _____	□ Intermittent Use (Social 1x 1-3 months)	□ Occasional Use (2-3 x monthly)	□ Daily Use (1-2 x Daily)
Drug Used? _____	□ Intermittent Use (Social 1x 1-3 months)	□ Occasional Use (2-3 x monthly)	□ Daily Use (1-2 x Daily)

Environmental Exposure:

□ Pets / Animals	□ Smoke (Non-Tobacco)	□ Smoke (2nd Hand)	□ Chemicals (_____)
How often exposed?	How often exposed?	How often exposed?	How often exposed?

Name:_____ Date of Visit: _____

Daily: _____	Daily: _____	Daily: _____	Daily: _____
Weekly: _____	Weekly: _____	Weekly: _____	Weekly: _____
Monthly: _____	Monthly: _____	Monthly: _____	Monthly: _____

Travel History:

Have you traveled outside of the US recently? Where and When?

Country / Date:	Country / Date:	Country / Date:	Country / Date:
/	/	/	/

Medication History:

List only medications currently being taken; include over the counter drugs and vitamins/supplements.

Name:	Dose: (2 x daily, etc)	Name:	Dose: (2 x daily, etc)

Past Surgical:

Name of Procedure:	Date Performed:	Where/Who performed by:

Diagnostic Studies:

Have you had any test(s) (x-rays, CT scan, MRI, etc) performed in preparation for your visit today?

****Female patients**: When was your last Mammogram? Date:_____

Name of Procedure/Lab:	Date Performed:	Where/Who performed by:

Name:_____ Date of Visit: _____

Comments:

Is there any *Medical History* or Comments related to your condition(s) that you would like to note?

_____
_____
_____
_____
_____

Review of Symptoms:

Are you experiencing or recently experienced any of the following:

General:	**Skin:**	**HENT:**	**Neck:**
□ Appetite Loss	□ Bruising	□ Headache	□ Neck Mass
□ Fatigue	□ Itching	□ Nasal Congestion	□ Swollen Glands
□ Fever	□ Nail Color Changes	□ Seasonal Allergies	□
□ Night Sweats	□ Rash	□ Sleep Apnea	□
□ Obesity	□	□ Snoring	□
□ Weight Gain	□	□ Hoarseness	□
□ Weight Loss	□	□	□
□ Unable to Sleep Lying Flat	□	□	□
□	□	□	□
Respiratory:	**Breast:**	**Cardiovascular:**	**Gastrointestinal:**
□ Bloody Sputum	□ Breast Mass	□ Chest Pain	□ Diarrhea
□ Cough	□	□ Edema	□ Difficulty Swallowing
□ Difficulty Breathing	□	□ Palpitations	□ Heartburn
□ Difficulty Breathing Exertion	□	□ Swelling in Extremities	□ Nausea
□ Sputum Production	□	□	□ Vomiting
□ Wheezing	□	□	□
□ Waking with Shortness of Breath or Wheezing	□	□	□
Musculoskeletal	**Neurological**	**Psychiatric**	**Endocrine**
□ Join Pain	□ Decreased Memory	□ Anxiety	□ Libido Changes
□ Muscle Pain	□ Seizures	□ Change in Sleep Pattern	□ Thyroid Problems
□ Muscular Weakness	□ Stroke	□ Depression	□
□	□ Weakness	□ Early Awakening	□
□	□	□ Easily Irritated	**Hematology**
□	□	□ Hypersomnia	□ Blood Clots
□	□	□ Impaired Cognitive Function	□ Enlarged Lymph Nodes
□	□	□ Inability to Concentrate	□
□	□	□ Insomnia	□
□	□	□ Panic Attacks	□
□	□	□ Trouble Falling Asleep	□