Pulmonary & Critical Care Associates, P.C.

MEDICAL INFORMATION SHEET

CHIEF COMPLAINT (What brings you into the office today)

Chief Complaint:	**Duration of symptoms:**

IMMUNIZATIONS (Record the date/year of last vaccine, if known)

Flu Vaccine:	**Pneumonia Vaccine:**

Have you ever received BCG for immunization against tuberculosis? YES NO

PAST MEDICAL HISTORY: (Please circle any of the conditions that you have now or have had in the past)

Acid Reflux	Collapsed Lung	Hepatitis	Pneumonia	Stroke
Angina/Chest Pain	Congestive Heart Failure	High Cholesterol	Pulmonary Fibrosis	Thyroid Disease
Arthritis	Cystic Fibrosis	Hypertension	Rashes	Tuberculosis
Asthma	Diabetes	Kidney Failure	Sarcoid	Ulcers
Blood Clots in Lungs/Legs	Emphysema/COPD	Lung Cancer	Seasonal Allergy	Other:
Cancer	Glaucoma	Obesity	Seizures	
Chest Tube	Heart Attack	Palpitations	Sinusitis	
Cirrhosis	Heart Murmur	Pleural Effusion (fluid on lungs)	Sleep Apnea	

PAST SURGICAL HISTORY: (Please circle all that apply and indicate year)

Appendectomy (appendix)	Cholecystectomy (gallbladder)	Ovaries	Tonsils
Bladder	Heart	Pacemaker	Uterus
Bowels	Hysterectomy	Prostate	Other:
Cesarean Section	Lung	Sinus	

SOCIAL HISTORY:

Cigarette Smoking		
Have you ever smoked? Yes No	If yes, for how many years?	How many packs per day?
When did you quit?	What things (nicotine gum, patch, etc.) have you tried to help you quit?	
Illicit Drug Use		
Have you ever used illegal drugs? Yes No	What did you use?	When was the last time?
Alcohol Use		
Do you drink alcohol? Yes No	How much?	How often?
Caffeine Use		
How often do you consume caffeine? Daily Rarely Never	What sources? (i.e. soda, coffee, tea, etc.)	How much?
General History		
What is your marital status?	Do you have pets at home? If yes, what pets?	

FAMILY MEDICAL HISTORY: (Please list your immediate family members (parents, grandparents, siblings, children), their relationship to you, along with their health status (living or deceased) and any related medical conditions (especially pulmonary conditions such as emphysema, asthma and lung cancer)

Family Member Name	Relation	Health Status	Medical Conditions
		Living / Deceased	
		Living / Deceased	
		Living / Deceased	
		Living / Deceased	
		Living / Deceased	

OCCUPATIONAL HISTORY: (Please list your last two jobs/occupations and include any occupational exposure to solvents, heavy metals, asbestos, organic or inorganic dusts or any other materials which you believe may be contributing to your lung status)

Job Description	Exposures

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REVIEW OF SYSTEMS

PATIENT INFORMATION (Please print)

(Please circle YES or No for the following symptoms)

GENERAL:			**MUSCULOSKELETAL**:		
Good General Health	YES	NO	Joint Pain	YES	NO
Fatigue	YES	NO	Muscle Cramps	YES	NO
Weight Loss	YES	NO	Back Pain	YES	NO
Fever	YES	NO	Joint Swelling	YES	NO
Chills	YES	NO			
Night Sweats	YES	NO	**PSYCHIATRIC**:		
			Depression	YES	NO
EYES:			Trouble Sleeping	YES	NO
Blurred Vision	YES	NO	Anxiety	YES	NO
Eye Pain	YES	NO			
			ENDOCRINE:		
EARS/NOSE/MOUTH/THROAT:			Excessive Thirst		
Postnasal Drip	YES	NO	Joint Pain	YES	NO
Sinus Congestion	YES	NO			
Facial Pain	YES	NO	**SKIN**:		
Hearing Loss	YES	NO	New Rashes	YES	NO
Frequent Nosebleeds	YES	NO	Varicose Veins	YES	NO
Sore Throat	YES	NO	New Moles	YES	NO
Clearing Throat	YES	NO			
			BLOOD/LYMPHATIC:		
CARDIOVASCULAR:			Swollen Glands/Lymph Nodes	YES	NO
Chest Pain	YES	NO	Easy Bruising	YES	NO
Palpitations/Racing Heart	YES	NO			
Shortness of Breath	YES	NO	**GENITOURINARY**:		
Swelling of Feet	YES	NO	Frequency of Urination	YES	NO
			Burning with Urination	YES	NO
RESPIRATORY:			Blood in Urine	YES	NO
Chronic or Frequent Cough	YES	NO	Difficulty Starting Urine	YES	NO
Spitting Up Blood	YES	NO	Leakage of Urine	YES	NO
Wheezing	YES	NO	Sexual Dysfunction	YES	NO
Sputum	YES	NO			
Cough/Aspirate at Mealtime	YES	NO	**ALLERGY**:		
			Itchy/Watery Eyes	YES	NO
GASTROINTESTINAL:			Hayfever	YES	NO
Nausea	YES	NO	Hives	YES	NO
Vomiting	YES	NO	Sneezing	YES	NO
Diarrhea	YES	NO			
Constipation	YES	NO			
Blood in Stool	YES	NO			
Heartburn	YES	NO			
Abdominal Pain	YES	NO			

CORNERSTONE PULMONARY CRITICAL CARE ASSOCIATES.

REGISTRATION INFORMATION

(**PLEASE PRINT**)

PATIENT INFORMATION

Patient's Last Name	First	Middle	Patient's Social Security No.:
Sex: ❑ M ❑ F	Age:	Birth Date:	❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Race: ❑ African American ❑ Asian ❑ Native American ❑ White ❑ Other		Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino Preferred Language:	
Street Address:	City:	State:	Zip:
Home Phone No.: ( )	Cell Phone No.: ( )	Responsible Party (if a minor):	
Contact E-Mail Address:			
Patient Employed By:		Occupation:	
Business Address:		Business Phone No.: ( )	
Spouse (or Responsible Party) Employed By:	Occupation:	Soc. Sec. #. of Spouse (or Responsible Party):	
Business Address:		Business Phone No.: ( )	
Your Pharmacy Name:		Pharmacy Phone No.: ( )	
Referred by:	Primary Care Physician:		

IN CASE OF EMERGENCY

Person to be notified in case of emergency:	Phone No.:

INSURANCE INFORMATION

Do you have medical insurance? ❑ Yes ❑ No *(If yes, please complete the following section)*	
Name of Primary Insurance:	
Policy Holder's Name:	Policy Holder's Birth Date:
Name of Secondary Insurance *(if any):*	
Policy Holder's Name:	Policy Holder's Birth Date:

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____ to pay and
(Name of Insured) (Name of Insurance Company)

hereby assign directly to _____ all benefits, if any, otherwise payable to me for his/her services as
(Provider's Name)

described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance

benefits, when received by and paid to _____ will be credited to my account, in accordance with
(Provider's Name)

the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

*****PLEASE HAND INSURANCE CARDS AND DRIVER'S LICENSE TO RECEPTIONIST WITH COMPLETED FORM*****

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MEDICATION LIST

LOCAL PHARMACY INFORMATION	
Pharmacy Name:	**Pharmacy Phone Number:**
Pharmacy Address:	
MAIL-ORDER PHARMACY INFORMATION	
Pharmacy Name:	**Pharmacy Phone Number:**

ALLERGIES to MEDICATION (Describe Reaction)	**ALLERGIES to FOOD/OTHER** (Describe Reaction)

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION / DOSE	DIRECTIONS: (How often do you use the medication)	Prescribing Doctor's Name