PHYSICIAN PARTNERS
PULMONARY, CRITICAL CARE, SLEEP SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Reason for today's visit?_____

Please check any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-stroke)
[ ] Asthma
[ ] COPD or Emphysema
[ ] Obstructive sleep apnea
[ ] Coronary Artery Disease
[ ] Congestive Heart Failure
[ ] Atrial Fibrillation
[ ] Chronic Sinus problems
[ ] Glaucoma
[ ] Pneumonia
[ ] Depression/Anxiety
[ ] Gastric Reflux
[ ] Liver Disease
[ ] Kidney Disease
[ ] Prostate Problems
[ ] Hepatitis
[ ] Bleeding/Clotting Problems
[ ] Abnormal Heart Rhythm
[ ] Thyroid Disease
[ ] Seizure Disorder
[ ] Chronic Pain
[ ] Sleep Disorder
[ ] Bipolar Disease
[ ] HIV/AIDS
[ ] Diabetes
[ ] Cancer _____
[ ] Anemia
Other: _____

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Family History: Please check the following health problems that have affected your family and identify their relationship to you, ie: mother, father, grandparent, sibling, child.

[ ] Adopted
[ ] Blood Clots _____
[ ] Bleeding Problems _____
[ ] High Blood Pressure _____
[ ] High Cholesterol _____
[ ] Thyroid problems _____
[ ] Heart Attack _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Lung disease _____
[ ] Asthma _____
[ ] Dialysis _____

Do you use tobacco? [ ]No [ ]Yes; if yes, packs /day: _____ Year Quit: _____

Do you drink alcohol? [ ]No [ ]Yes; if Yes, drinks per day _____ Per week: _____

Do you use recreational drugs? [ ]No [ ]Yes; if yes, describe: _____

Have you worked with asbestos products? [ ] No [ ] Yes; if yes, describe the job_____

Have you been exposed to tuberculosis? [ ] No [ ] Yes; if yes, please describe _____

Last PPD Date; _____ Results: [ ] Normal [ ] Abnormal

PHYSICIAN PARTNERS
PULMONARY, CRITICAL CARE, SLEEP SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____DOB: _____

If you have had the following vaccines, please document the dates given:

Flu _____ Shingles _____ Pneumovax _____ Prevnar _____

Have you lost interest in doing things that use to give you pleasure?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you been feeling down, depressed or hopeless in the past 2 weeks?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you experienced 10 lbs weight loss or weight gain in the past 3 months? [ ] No [ ] Yes

Do you have problems with mobility (use a wheelchair, cane or walker)? [ ]No [ ] Yes; if yes, please describe the problem and/or the device used._____

Have you had a fall in the past year? [ ] No [ ] Yes

Do you feel unsteady? [ ] No [ ] Yes

Are you in a relationship where you are being threatened or hurt? [ ] No [ ] Yes

EPWORTH SLEEPINESS SCALE

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation below:

0=Would never dose 1= slight chance of dozing 2= Moderate chance of dozing 3= High chance of dozing

- Make sure to check a number for each situation

Sitting & Reading ……	[ ]0	[ ]1	[ ]2	[ ]3
Watching Television ……	[ ]0	[ ]1	[ ]2	[ ]3
Sitting inactive in public place ……	[ ]0	[ ]1	[ ]2	[ ]3
As a passenger in a car for an hour without a break ….	[ ]0	[ ]1	[ ]2	[ ]3
Lying down to rest in the afternoon ……	[ ]0	[ ]1	[ ]2	[ ]3
Sitting and talking to someone ……	[ ]0	[ ]1	[ ]2	[ ]3
Sitting quietly after lunch without alcohol ……..	[ ]0	[ ]1	[ ]2	[ ]3
In a car, while stopped in traffic ……	[ ]0	[ ]1	[ ]2	[ ]3

Total score (*add all of the above scores)* _____ (Max= 24; Normal <10)

PHYSICIAN PARTNERS
PULMONARY, CRITICAL CARE, SLEEP SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____ **Date of Birth** :_____/_____/_____

List Drug, Food, or Substance Allergies & Reactions:

_____
_____
_____

Preferred Pharmacy:_____ **Pharmacy Location:**_____

Complete your medication list to the best of your ability:

Date	Drug	Dose	Frequency	Indication

***Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.