Carolina Pulmonary
Critical Care and Sleep Medicine
A Lexington Medical Center Physician Practice

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New Patient Packet

Dear Patient_____,

Thank you for choosing Carolina Pulmonary, Critical Care, and Sleep Medicine for your medical needs. We know you have a choice and we will do everything possible to earn and keep your trust in us.

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

- ☐ **Completed Patient Information Form**
- ☐ **Completed Patient History and Physical Packet**
- ☐ **Insurance Card(s)**
- ☐ **CD and report of chest X-rays/scans and/or recent sleep study**
- ☐ **All of your current medications**

Hours of Operation	8:00 a.m. – 5:00 p.m.
Phone Calls	Monday – Friday 8:30 a.m. – 4:30 p.m. for routine calls including prescription refills, appointment scheduling and billing questions.
After-hours Phone Calls	Please reserve any phone calls between 4:30 p.m. and 9:00 a.m. for emergencies only. Should you need to call after hours for routine reasons we reserve the right to charge a $25.00 fee.
Cancellation Policy	Please call to cancel any appointments you will be unable to keep at least 24 hours in advance so we may offer these appointments to other patients in need of treatment. Multiple missed appointments could result in dismissal from our practice. Your appointment time is reserved for you so please let us know in advance if you are unable to honor that appointment.
Insurance and Patient Billing	As a service to our patients, we will send claims to your primary and, if applicable, to your secondary insurance carrier on your behalf. Co-pays, co-insurance, and deductibles are due at the time of service. A detailed description of our Financial Policies is displayed in our lobby and at check-out. We accept cash (including money orders and personal checks) and Visa/ Master Card/ Discover as payment for the services rendered.

PLEASE DO NOT WEAR PERFUME, COLOGNE, OR SCENTED LOTION WHEN VISITING OUR OFFICE AS IT CAN AGGRAVATE THE BREATHING PROBLEMS OF OTHERS.

Please keep this page for your reference.

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Patient Medical History

Name:_____

Age:_____ **Date:**_____ **Referring Physician:**_____

Please fill out all questions that apply.

What is the primary reason for your visit today?

_____

_____

Check off any of the following problems that you have:

☐ Shortness of breath ☐ Asthma ☐ Heart disease ☐ Cancer
☐ Wheezing ☐ Reflux ☐ Sleep apnea ☐ Heart failure
☐ Chronic cough ☐ Diabetes ☐ Night sweats ☐ Leg cramps
☐ COPD ☐ Chronic back pain ☐ Coughing up blood ☐ Stroke

Any not listed?_____

Have you ever had any of the following?

☐ Pulmonary stress test ☐ PFT ☐ Bronchoscopy ☐ Pneumonia
☐ EKG ☐ Lung cancer ☐ Exposure to TB ☐ Blood Clot

List any surgeries and the approximate date they were performed:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Family history of medical problems

Mother:_____ Brother(s):_____
Father:_____ Other:_____
Sister(s):_____ _____

Social History

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

With whom do you live:_____

What is your occupation:_____

Do you have any pets: ☐ Yes ☐ No

If yes, what kind:_____

Who is your primary doctor?_____

Do you see any other specialists?_____

_____

_____

Social History (continued)

Do you exercise (including walking)? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Currently ☐ Former ☐ Never

Start Date:_____ Quit Date:_____

How many packs per day?_____

For how many years?_____

Do you vape? ☐ Currently ☐ Former ☐ Never

Do you use smokeless tobacco? ☐ Currently ☐ Former ☐ Never

Do you use recreational drugs? ☐ Currently ☐ Former ☐ Never

List:_____

Do you drink caffeinated beverages? ☐ Yes ☐ No

How many?_____

Do you drink alcohol? ☐ Yes ☐ No

How much?_____

Any occupational exposures? ☐ Yes ☐ No

Asbestos: ☐ Yes ☐ No **Solvents/Chemicals?** ☐ Yes ☐ No

Military Service? ☐ Yes ☐ No

Agent orange or other exposure? ☐ Yes ☐ No

List:_____

Sleep History

Have you ever had a sleep study? ☐ Yes ☐ No

When?_____ Where?_____

Are you on a CPAP/BiPAP? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

How long?_____ Is it worsening? ☐ Yes ☐ No

Has anyone noticed that you stop breathing or gasp/choke while sleeping? ☐ Yes ☐ No

Do you and your bed partner sleep in separate rooms because of your snoring or restless sleep? ☐ Yes ☐ No

Have you gained any weight over the last year? ☐ Yes ☐ No

If so, how much?_____

Do you feel sleepy during the day? ☐ Yes ☐ No

Do you have trouble with memory or concentration? ☐ Yes ☐ No

Do you get irritable easily? ☐ Yes ☐ No

Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience? ☐ Yes ☐ No

Do you ever have bizarre dreams? ☐ Yes ☐ No

Do you ever lay in bed and feel paralyzed?

☐ Yes ☐ No

What is your bedtime? _____

What time do you get up?_____

Do you wake up in the middle of the night? ☐ Yes ☐ No

If yes, how many times per night?_____

Do you fall asleep again easily? ☐ Yes ☐ No

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following circumstances?

Please use the following scale:

0 = would never doze off 1 = slight chance of dozing off

2 = moderate chance of dozing 3 = high chance of dozing

_____ sitting and reading

_____ watching television

_____ sitting inactive in a public place

_____ while a passenger in a car without a break

_____ lying down to rest in the afternoon when circumstances permit

_____ sitting and talking to someone

_____ sitting quietly after lunch without alcohol

_____ in a car, while stopped in traffic for a few minutes

Epworth Score:_____ **Date:**_____

Review of Symptoms (Please check the box by any symptom you have)

Constitutional
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Excessive sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

Eyes
- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ Visual disturbance

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urine

Allergy/Immunology
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Immunocompromised

HENT
- ☐ Congestion
- ☐ Dental problem
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Nosebleeds
- ☐ Postnasal drip
- ☐ Runny nose
- ☐ Sinus pressure
- ☐ Sneezing
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ Trouble swallowing
- ☐ Voice change

Respiratory
- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Neurological
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Lightheadedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

GU
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Bed wetting
- ☐ Flank pain
- ☐ Frequency
- ☐ Genital sore
- ☐ Blood in urine
- ☐ Menstrual pain
- ☐ Pelvic pain
- ☐ Urgency
- ☐ Urine decreased
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal pain

Sleep
- ☐ Morning fatigue
- ☐ Morning headache
- ☐ Excessive daytime sleepiness
- ☐ Nighttime urination
- ☐ Sinus congestion
- ☐ Snoring
- ☐ Restless legs
- ☐ Dry mouth
- ☐ Trouble concentrating

Muscular
- ☐ Arthralgias
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Neck stiffness

Hematologic
- ☐ Adenopathy
- ☐ Bruises/bleeds easily

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

GI
- ☐ Abdominal distention
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Skin
- ☐ Color change
- ☐ Paleness
- ☐ Rash
- ☐ Wound

Psychiatric
- ☐ Agitation
- ☐ Behavior problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Dysphoric mood
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal ideas

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Universal Medication Form

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Name:_____ Date form started: _____

Birth Date:_____ Emergency Contacts (name and number)

Address:_____ 1_____ ( ) _____–_____

Phone Number:_____ 2_____ ( ) _____–_____

Preferred Pharmacy:_____ DME Company:_____

IMMUNIZATION RECORD (Record the date/year of the last dose taken, if known)

Tetanus:_____ Flu Vaccine(s)_____ Other:_____

Pneumonia Vaccine:_____ Hepatitis Vaccine:_____ _____

Allergic To	Describe Reaction	Allergic To	Describe Reaction

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

DATE	Name of Medication and Dose	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	NOTES: Reason for taking and Doctors Name