



# Pulmonary and Critical Care Associates

NG#: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Type of visit: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Male  Female Date of Birth: \_\_\_\_\_ PCCA Provider: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_  None  Email Refused

**Primary Care Provider:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact:** (ICE: In Case of Emergency)

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ ext: \_\_\_\_\_

**Preferred Pharmacy Information:**

1<sup>st</sup> Choice: Name of Pharmacy: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

2<sup>nd</sup> Choice: Name of Pharmacy: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

**Insurance Information:**

Primary Insurance:

Insurance Name: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance:

Insurance Name: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Tertiary Insurance:

Insurance Name: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ D.O.B \_\_\_\_\_  
 Appointment Date: \_\_\_\_\_

**Past Medical History Information:** (Please mark all that apply.)

Depression	Lung Cancer	Congestive Heart Failure	Allergic Rhinitis
Thyroid Disease	Colon Cancer	High Blood Pressure	Freq. Heartburn
Asthma	Breast Cancer	Renal Failure/Insuff.	Narcolepsy
Emphysema	Prostate Cancer	Ulcers	Pulmonary Fibrosis
Diabetes	Seizures	Liver Disease	Sleep Apnea
Blood Clot in Lung	Stroke	Hepatitis	TB
Blood Clot in Leg	Coronary Artery Disease	Atrial Fibrillation	

Other Medical Problems:

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**Past Surgical History Information:** (Please mark all that apply and add year.)  Check here for "No Surgery Ever"

Surgery/Year	Surgery/Year	Surgery/Year	Surgery/Year
Heart Valve Repl.	Stomach Surgery	Knee Replacement	Thoracotomy
Coronary Artery Bypass	Tonsillectomy	Fracture Repair	UPPP
Appendectomy	Gall Bladder Removal	Glaucoma Surgery	Tracheostomy
Splenectomy	Brain Surgery	Cataract Surgery	Pacemaker
Colon Surgery	Back Surgery	Lung Surgery	Cardiac Stent
Hernia Repair	Hip Replacement		

Other Surgeries (Please include All Other Surgeries):

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**Family History Information:** (Please mark all that apply.)

Heart Disease	Breast Cancer	Asthma	Chronic Bronchitis	Hx of Smoking
Lung Cancer	Bleeding Disorder/Clots	Emphysema	Sleep Apnea	TB
Other:				

**Social History Information:**

Caffeine Use? Y N Type: \_\_\_\_\_ Amt/Day: \_\_\_\_\_  
 Tobacco Use? Y N Former Type: \_\_\_\_\_ Amt/Day: \_\_\_\_\_ Yrs: \_\_\_\_\_ (Yr quit: \_\_\_\_\_)  
 Alcohol Use? Y N Former Type: \_\_\_\_\_ Amt/Day: \_\_\_\_\_ Freq: \_\_\_\_\_ (Yr quit: \_\_\_\_\_)  
 Recreational drug use? Y N Former Type: \_\_\_\_\_  
 Exercise? Y N Type: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_  
 Number of Children: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ D.O.B \_\_\_\_\_  
 Appointment Date: \_\_\_\_\_

**Review of Systems:** Please circle all symptoms that apply to you. All symptoms not circled will be considered negative.

<b>CONSTITUTIONAL</b>	<b>GASTROINTESTINAL</b>	<b>NEUROLOGICAL</b>
Fatigue	Abdominal Pain	Dizziness
Fever	Blood in Stool	Headache
Night Sweats	Difficulty Swallowing	Memory Loss/Impairment
Weight Gain	Vomiting blood	Seizures
Weight Loss	Black, Tarry Stools	Visual Changes
	Nausea	
<b>HEENT</b>	Reflux	<b>PSYCHOLOGICAL</b>
Hearing Loss	Vomiting	Depression
Nasal Drainage		Hallucinations
Nosebleeds	<b>GENITOURINARY</b>	
Nasal Congestion	Blood in Urine	<b>DERMATOLOGIC</b>
	Frequent Night Urination	Rash
		Skin Sores
<b>RESPIRATORY</b>	<b>REPRODUCTIVE</b>	
Cough	Sexual Dysfunction	<b>MUSCULOSKELETAL</b>
Shortness of Breath	History of Oral Contraceptives	Bone/Joint Pain
Bloody Sputum		Muscle Pain
Snoring	<b>ENDOCRINE</b>	Muscle Weakness
Wheezing	Cold Intolerance	Muscle Spasms
	Profuse Sweating	
<b>CARDIOVASCULAR</b>	Goiter	<b>HEMATOLOGIC</b>
Chest Pain	Heat Intolerance	Low Platelet Count
Ankle Swelling	Tremors	Acute Anemia
Palpitations		
Fainting Spells		

