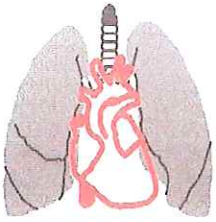

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 29303
864-582-6858

New Patient Form

Date: _____

Last Name:_____ First Name:_____
Middle Initial:_____ How do you prefer to be addressed?_____
Date of Birth _____
Street Address:_____
City:_____ State:_____Zip: _____

Who referred you to our office? _____
Who is your primary care doctor? _____
How did you hear about our office? _____

I. **Why are you here today** (Chief Complaint)? _____

1. How long have you had this health problem? _____
2. How did it start? _____
3. Has anything made it better or worse?

_____
_____
_____

II. **Current Medications** (list all prescribed and over the counter medications including inhalers and vitamins):

_____
_____
_____
_____
_____
_____

III. **Medical History** (Please circle all that apply):

Asthma
Allergies
Abnormal Chest X-Ray
COPD
Sinusitis
Lung Cancer
TB (Tuberculosis)
Pneumonia
Sleep Apnea
Narcolepsy
Chronic Bronchitis
Cystic Fibrosis
Cough
Asbestosis
Lung injury
Sarcoid
Cataracts
Other: _____

Heart Attack
CHF (Heart Failure)
High Blood Pressure
Pulmonary Hypertension
Pulmonary Embolus
DVT (Blood Clot in leg)
Atrial Fibrillation
Mitral Valve disease
Hole in Heart
Heart murmur
Aortic Valve disease
AAA (Aortic aneurysm)
Circulation Problems
Stroke or TIA
Clotting Problems
Vascular Disease
Glaucoma

Cancer of:
- Brain
- Breast
- Head and Neck
- Stomach
- Colon
- Kidney
- Prostate
- Uterus (Womb)
- Skin
- Lymphoma/Leukemia
- Ovary
- Other

Diabetes
Thyroid Problems
Adrenal problems

Peptic Ulcer Disease
Crohn's Disease
Ulcerative Colitis
Osteoporosis
Pancreatitis
Seizures
Parkinson's Disease
Osteoarthritis (DJD)
Rheumatoid Arthritis
Lupus (SLE)
Scleroderma
Vasculitis
Scoliosis
Muscular Dystrophy
Kidney Failure
MRSA

IV. **Allergies** to medications or foods (Please explain reaction):

_____

_____

V. **Surgical History** (Please circle all that apply and add month/year):

Lung Surgery _____ Hysterectomy_____ Spine surgery_____
Cardiac Stent _____ Mastectomy_____ Tonsillectomy (T&A) _____
Pacemaker_____ Breast Biopsy_____ Sinus surgery _____
AICD_____ Prostate Surgery_____ Snoring surgery_____
Heart By Pass_____ Gallbladder_____ Transplant _____
Abdominal Aortic Aneurysm_____ Knee Replacement_____ Thyroid _____
Vascular graft_____ Hip Replacement_____ Appendectomy_____
Gastric By-Pass_____ Hiatal Hernia Repair_____ Hernia _____
Implanted Defibrilator_____ Heart Valve replacement_____
Other _____

VI. **Other Hospitalizations** (Give reason and month/year):

_____

_____

_____

VII. **Family History**:

Mother Alive/Deceased Age/Age at death _____ Health Conditions/Cause of death_____
Father Alive/Deceased Age/Age at death_____ Heath Conditions/Cause of death_____
Sisters Ages_____ Health Conditions_____
Brothers Ages_____ Health Conditions_____

Family Medical Conditions (Circle those that apply):

Asthma
Hay fever/Allergies
Emphysema
Lung Cancer
High Blood Pressure
Heart Disease
Stroke
Diabetes
TB (Tuberculosis)
Clotting problems
Vascular Disease
Sleep Apnea
Kidney disease
Mental Illness
Pulmonary Fibrosis (IPF)
Other Cancer:_____
_____
Other: _____

VIII. **Social History**:

1. **Smoking History**: Never Past: Year quit:_____ Current
   Age started _____ Maximum packs/day_____ Current packs/day_____
   How many years did you smoke?_____
   Do you want help stopping? _____
   Does anyone else in your home smoke? Yes No
2. **Marital Status** (circle): Married Single Divorced Separated Widowed
3. **Education Level** (circle): Grade School 8th grade High School Some College
   College Degree Graduate Degree
4. **Occupation** (circle): Full-time Part-time Retired Disabled Unemployed Student
   Types of work done: _____
   Exposures: Dust Fumes Solvents Silica Paint Asbestos Dyes Chemicals
   Military Service: No Yes:_____
5. **Alcohol use** (circle): Never Past Current Amount:_____
6. **Recreational Drug use** (circle): Never Past Current
   Type (circle): cocaine crack marijuana heroin meth narcotics
7. **Regular Exercise**: _____
8. **Hobbies**:_____
9. **Travel outside Upstate**: _____

IX. **Review of Systems** (Circle all that apply):

1. **Sleep History**:	Snores	Day-time Sleepiness	Fatigue on Waking	
2. **Constitutional:**	Fever/chills Night sweats	Weight gain: Amount: _____ Weight loss: Amount: _____		
3. **ENT:**	Dentures Sore throat	Nasal discharge Sinus Pain	Hearing loss	
4. **Respiratory:**	Shortness of breath	Dry cough	Productive cough	
	Wheezing	Increased Wheezing	Chest tightness	
	Blood Clots in Lungs	Blood Clots in Legs	Chest wall pain	
	TB exposure	TB skin test: Positive	Negative	
	Home nebulizer	Home oxygen	Home ventilator	
5. **Cardiology:**	Heart trouble Palpitations	High Blood Pressure	Leg swelling	
6. **GI:**	Nausea	Vomiting	Heartburn	Diarrhea
7. **Urology:**	Kidney stones	Kidney disease	Chronic dialysis	
8. **Neurology:**	Memory Loss CVA/TIA	Tingling/Numbness Seizures		
9. **Endocrinology:**	Diabetes	Hypothyroid	Hyperthyroid	
10. **Dermatology:**	Rash	Hives	Bruises	Skin Cancer
11. **Allergy:**	Runny nose	Scratchy throat	Previous skin testing	
12. **Musculoskeletal:**	Leg cramps	Disc disease		
	Cane	Walker	Crutch	Wheelchair	Scooter
13. **Ophthalmology:**	Glasses/Contacts	Glaucoma	Cataracts	Macular degeneration
14. **Psychology:**	Depression	Anxiety		

X. **Vaccines**: Pneumovac Date: _____Flu Date: _____
Tetanus Date: _____

XI. Do you have a living will?_____

XII. **Other Information** (Please write anything else that the doctor needs to know below):