

**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.

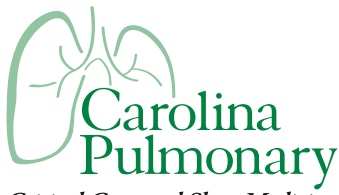
**After-hours Phone Calls**      Please reserve any phone calls between 4:30 p.m. and 9:00 a.m. for emergencies only. Should you need to call after hours for routine reasons we reserve the right to charge a \$25.00 fee.

**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.**



Critical Care and Sleep Medicine  
A Lexington Medical Center Physician Practice

Lexington Medical Park 2  
146 E. Hospital Drive, Suite 400  
West Columbia, SC 29169  
Phone: (803) 256-0464 • FAX: (803) 254-5121  
**CarolinaPulmonary.com**

Northeast Columbia  
720 Rabon Road  
Columbia, SC 29203  
Phone: (803) 936-8900 • FAX: (803) 935-8667

## 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:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart disease     | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Reflux            | <input type="checkbox"/> Sleep apnea       | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> Chronic cough       | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Night sweats      | <input type="checkbox"/> Leg cramps    |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Stroke        |

Any not listed? \_\_\_\_\_

**Have you ever had any of the following?**

- |  |                                      |   |                                     |
|--|--------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Pulmonary stress test | <input type="checkbox"/> PFT         | <input type="checkbox"/> Bronchoscopy   | <input type="checkbox"/> Pneumonia  |
| <input type="checkbox"/> EKG                   | <input type="checkbox"/> Lung cancer | <input type="checkbox"/> Exposure to TB | <input type="checkbox"/> 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

\_\_\_\_\_ laying 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
- Light-headaches
- 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

