**New Patient Intake Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Birth: |  |
| Address: |  |  | Phone: |

**Current Medications:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupational history**

Have you ever **worked in** or with the following :

|  |  |  |  |
| --- | --- | --- | --- |
| Mine | Quarry | Foundry | Flax,cotton, or hemp mill |
| Abrasives Factory | Chemical Plants | Pottery | Glass or Ceramics factory |

Have you ever **worked with**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Asbestos | Sandblaster | Coal | Wood Dust | Uranium |
| Plastics | Toluene di-isocynate (TDI) | Irritants | Chemicals | Fumes |
| Grain Dust | Solvents | Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Illnesses**

Have you ever had the **following conditions**? Please circle all that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Asthma | Allergies | Auto-immune | Chronic Bronchitis | Emphysema |
| Pneumonia | Pneumothorax (collapsed lung) | Tuberculosis | Sinusitis | Diabetes |
| Heart Problems | Eczema | Scleroderma | Cancer | Reflux or GERD |

**Surgical History**

Have you ever had surgeries to your chest, nose, sinuses, and upper abdomen?

\_\_\_\_\_\_\_\_\_\_\_\_ If yes, Why? When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations**

|  |  |  |
| --- | --- | --- |
| Date | Hospital | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Family History**

Have you had any family members who have had any respiratory conditions?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you visited any physicians for your respiratory conditions? Who, when, and why?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of cancer? Who and what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Have you ever smoked cigarettes?

* Yes, \_\_\_\_ Packs per day
* No, but I vape or use electronic cigarettes
* No, but I smoke medical marijuana or or tetrahydrocannabinol (THC) products
* No, but I smoke a pipe or cigar since \_\_\_\_\_\_\_\_\_\_\_\_
* No, but I smoked in the past and I quit in \_\_\_\_\_\_\_\_\_
* No, I have never been a smoker.

Alcohol Intake: Daily Every other day Weekends Monthly or less

How many drinks do you have at a time : 1-2 3-4 5-6 drinks

How often have you had more than 6 drinks over the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you smoked marijuana?\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreation drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of drug overdose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home / Apartment

**Symptoms**

**Do you cough? Please circle all that apply:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Almost every day | Several Days a Week | A few days a Month | Only with Respiratory Infections | Not at all |
| Painful | Disturbs sleep | Exhausts me | Embarassing |  |

**Do you bring up or produce sputum or phlegm? Please circle all that apply:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Thick | Thin | | Clear | White | | Yellow | | Green | Bloody | | Brown |
| Almost every day | | Several Days a Week | | | A few days a Month | | Only with Respiratory Infections | | | Not at all | |

**Do you have chest pain?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Almost every day | Several Days a Week | A few days a Month | Only with Respiratory Infections | Not at all |

**Do you have chest pain?**

Where is your chest pain located?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does it feel like?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the chest pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the chest pain better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have shortness of breath?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Almost every day | Several Days a Week | A few days a Month | Only with Respiratory Infections | Not at all |

Are you short of breath in the following situations (circle all that apply):

|  |  |  |
| --- | --- | --- |
| * Sitting or lying still | * Washing or dressing yourself | * Walking in the house |
| * Walking outside on level ground | * Walking up hills | * Playing sports or other physical activities |
| * Speaking | * Bending Over |  |

Does your breathing make it difficult to (circle all that apply):

|  |  |  |
| --- | --- | --- |
| * Carry things up stairs | * Walk up hills | * Carry heavy loads |
| * Light gardening | * Shoveling snow | * Jogging or walking briskly |
| * Tennis | * Swimming | * Dancing |
| * Bowling | * Golfing | * Shopping |
|  |  |  |

Do you **wheeze?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Almost every day | Several Days a Week | A few days a Month | Only with Respiratory Infections | Not at all |

**Is your wheezing worse when you get up in the morning**? Yes or No

How many times in the past 4 weeks have you suffered from **severe or very unpleasant respiratory attacks**? Circle the best answer:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| More than 3 times | 3 times | 2 times | 1 time | None of the time |

How long do your **respiratory attacks** last?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| A week or more | 3+ days | 1-2 days | Less than a day |  |

Over the last 4 weeks, in a typical week, how **many good days** have you had?

|  |  |  |  |
| --- | --- | --- | --- |
| No good days | 1-2 good days | 3-4 good days | Nearly every day is good |

Which statement best describes your **respiratory condition**:

* The most important problem I have
* Causes me quite a lot of problems
* Causes me a few problems
* Causes me no problems.

If you ever held a job, what best applies:

* My respiratory problems made me stop working altogether
* My respiratory problems interfere with my job or made me change my job
* My respiratory problems do not affect my job

|  |  |  |
| --- | --- | --- |
| TRUE | FALSE | My respiratory problems are a nuisance to my family, friends, and neighbors. |
| TRUE | FALSE | I get afraid and panic when I can't catch my breath. |
| TRUE | FALSE | I feel that I am not in control of my respiratory problems. |
| TRUE | FALSE | I do not expect my respiratory problems to get better. |
| TRUE | FALSE | I have become frail or invalid because of my respiratory problems. |
| TRUE | FALSE | Exercise is not safe for me. |
| TRUE | FALSE | Everything seems too much of an effort. |
| TRUE | FALSE | I cannot play sports or do other physical activities. |
| TRUE | FALSE | I cannot go out for entertainment or recreation. |
| TRUE | FALSE | I cannot go out of the house or do the shopping. |
| TRUE | FALSE | I cannot do household chores. |
| TRUE | FALSE | I cannot move from the bed to the chair. |
| TRUE | FALSE | My shortness of breath disturbs my sleep. |
| TRUE | FALSE | My shortness of breath is embarrassing in public. |
| TRUE | FALSE | I take a long time to get washed and dressed |
| TRUE | FALSE | I cannot take a bath or shower or I take a long time to do it. |
| TRUE | FALSE | I walk slower than other people my age, or I have to stop to rest. |
| TRUE | FALSE | Household chores take a long time and/or I have to stop and rest. |
| TRUE | FALSE | If I walk up one flight of stairs, I have to stop or go slowly. |
| TRUE | FALSE | If I hurry or walk fast, I have to stop or slow down. |
| TRUE | FALSE | My respiratory problems do not stop me from doing anything I would like to do. |
| TRUE | FALSE | My respiratory problems do not stop me from doing one or two things I would like to do. |
| TRUE | FALSE | My respiratory problems stop me from doing most of the things I would like to do. |
| TRUE | FALSE | My respiratory problems stop me from doing everything I would like to do. |

Have you received the following treatments in the past **for your respiratory problems:**

* Oxygen / CPAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Inhalers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Nebulizer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Pills :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Injectable medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you currently have an inhaler, which ones are your using:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatments have you tried and failed, when did you try them? What happened? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep Questionnaire:**

Are you able to fall asleep in 15 minutes or less? \_\_\_\_\_

Do you wake up several times during the night or have a hard time falling asleep? \_\_\_\_\_

When did your difficulty sleeping begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it more difficult to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your difficulty sleeping associated with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What sleeping aids (over the counter and prescription) have you tried? Which medications worked, did not work, or worked temporarily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you awake feeling well rested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you find it difficult to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Patient Representative’s Signature