Name_____DOB_____

New Patient Questionnaire Packet

The following pages contain important questions that will assist us in providing the best care possible.

Reason for Visit/Current Visit:

Referred by:

Other Physicians involved in care:

Pharmacy:

Tobacco use: **Cigarettes** Y N **Amount:** _____ **Age from** _____ **to** _____

Other: Please list:

Alcohol: **Amount per week:** _____ **Product:** _____

Medications including Inhalers:

Oxygen/CPAP/BIPAP:

Allergies:

Family History (Focus on Lung conditions, Allergic conditions, Heart conditions, and any cancers)

Parents: **Father** **Mother**

Name_____DOB_____

Siblings:

Children:

Past Medical History:

Current Medical Conditions:

Recent Hospitalizations/Surgeries:

Lab Work:

X-Rays/CT Scans/PET Scans:
Breathing Tests:

Other:

Name_____DOB_____

Occupational History: Please list all jobs, types of work since completion of school.

Please add any additional comments or information you believe is helpful.

Current Problems: CHECK IF YES

General **N/A**_____	_____ Wt Loss _____ Wt Gain _____ How Much? _____ Fatigue _____ Malaise _____ Weakness _____ Loss of Appetite _____ Pain
Eyes **N/A**_____	_____Vision Loss _____ Blurring _____ Irritation
Nose **N/A**_____	_____ Discharge _____ Bleeding _____ Sinus Problems
Throat **N/A**_____	_____ Sore _____ Swallowing Problem _____ Voice Change
Heart **N/A**_____	_____ High Blood Pressure _____ Tightness _____ Edema/Swelling _____ Irregular Heartbeat/Palpitations _____ Murmur _____ Pain
Lungs **N/A**_____	_____ Cough _____ Infections _____ Fever _____ Snoring _____ Sputum (Color) _____ Blood _____ Shortness of Breath _____ Wheeze _____ Asthma _____ Sleep Impairment _____ Pain
GI **N/A**_____	_____ Heartburn _____ Constipation _____ Bleeding _____ Diarrhea _____ Ulcers _____ Infection _____ Other

Name_____DOB_____

Kidneys **N/A**_____	_____ Pain _____ Infection _____ Stones _____ Other
Musculoskeletal **N/A**_____	_____ Arthritis _____ Pain _____ Osteoporosis _____ Surgery
Skin **N/A**_____	_____ Cancer _____ Bruising _____ Rash
Nervous System **N/A**_____	_____ Headache _____ Stroke _____ Seizure _____ Numbness
Mental **N/A**_____	_____ Anxiety _____ Depression _____ Bipolar _____ Addiction
Endocrine **N/A**_____	_____ Diabetes _____ Thyroid Disease _____ Other
Blood **N/A**_____	_____ Anemia _____ Malignancy _____ Clots
Allergies N/A____	_____ Seasonal _____ Medications _____ Food _____ Other
Infections **N/A**_____	_____ HIV _____ Chronic _____ Other

SUBURBAN PULMONARY MEDICINE, P.C.

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PULMONARY DISEASE
CRITICAL CARE
OCCUPATIONAL LUNG DISEASE

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, Suburban Pulmonary Medicine, P.C., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that Suburban Pulmonary Medicine, P.C., its employees, and/or agents may contact me/us as described above.

_____ _____

Name DOB

_____ _____

Responsible Party Signature Date