TARRANT PULMONARY ASSOCIATES
PATIENT FORM

Phan Nguyen MD

601 Omega Drive, Suite 208
Arlington, TX 76014
Tel. (682) 323 7006
Fax. (888)720 1899

Patient Name:_____
Referring Physician:_____
You have been scheduled for an initial consultation or hospital follow-up appointment with _____ on _____ at _____ with a check-in time of _____. Below is a list of important information to assist you in preparing for this appointment.

- Please complete the enclosed packet of paperwork prior to your appointment. Be sure that all highlighted lines have a signature. The HIPAA privacy information is available in our office for your review if you are not already familiar with its contents.
- It is very important that the doctor have any old and new chest x-rays, CT chest scans or PET scans (**patient must bring the actual films** and reports) for this appointment. (This does not apply to hospital follow-up patients.)
- Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- You must bring all of your current medications with dosage and frequency. You may bring the medication bottles if you prefer and the clinical staff can list them in your chart.
- New patients should plan to be in the office for a period of two hours. Patients seen in follow-up after hospitalization should plan approximately one hour for the appointment.
- If your insurance requires a referral, please make sure your referring physician has this completed and faxed to our office prior to your appointment.
- Many of our patients have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.
- As a courtesy to our patients, we file charges to your insurance, but all co-payments are expected at the time of service.
- **If you cannot keep your appointment, please call us at (682) 323-7006 as early as possible. Please help us serve you better by keeping scheduled appointments.**

We look forward to meeting you at your first office visit. If we can assist you with questions prior to your visit, please feel free to call. You may also see our website at www.tarrantpulmonary.com for answers to questions you may have.

Sincerely,

Scheduling Secretary

PATIENT QUESTIONNAIRE:

Patient Name: _____ **Date:** _____

Why are you here to see the doctor today? Briefly describe your pulmonary (lung) problem. Tell when and how it began.

_____
_____
_____

Have you ever had any pulmonary (lung) problems as a child (asthma, wheezing, shortness of breath, recurrent lung infections)? If yes, please list the problems.

_____
_____

Respiratory symptoms:
Shortness of breath:

When do you have shortness of breath?

☐ ***On exertion*** ☐ ***At rest*** ☐ ***Both***

How long has this been going on (***days, weeks, months or years***)? _____

If your shortness of breath happens on exertion, approximately how far can you walk or how much activity can you do before you become short of breath? _____

_____

Does shortness of breath come on suddenly? ☐ **Yes** ☐ **No**

What, if anything, makes the shortness of breath **better** or **worse**?

Does it improve after coughing up thick sputum? ☐ **Yes** ☐ **No**

Is it improved after taking any particular medications? ☐ **Yes** ☐ **No**

If **Yes,** which medication _____

Is it worse in any particular position (i.e.: lying down, bending over)?

_____

Is it worse after eating? ☐ **Yes** ☐ **No**

Is it worse with exposure to ☐ ***dust*** ☐ ***fumes*** ☐ ***cold air*** ☐ ***other*** _____

_____

Is the shortness of breath associated with: **Check all that apply.**

☐ ***Drenching sweats***	☐ ***Blackouts***	☐ ***Chest pain***	☐ ***Fever***
☐ ***Swollen legs***	☐ ***ckouts***	☐ ***Nausea/vomiting***	
☐ ***Pounding heart***	☐ ***Chills***	☐ ***Wheezing***	

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Cough:

How long have you had trouble with coughing? _____

Has your cough changed recently? ☐ **Yes** ☐ **No**
** If **yes**, how has it changed? _____

Has your cough ever awakened you from sleep? ☐ **Yes** ☐ **No**

** If **yes**, how often does this occur? _____

Does your cough produce sputum? ☐ **Yes** ☐ **No**

****** If **yes**, what color? (Check one or more)

☐ ***Clear*** ☐***yellow*** ☐***white*** ☐***green*** ☐ ***tan*** ☐ ***brown*** ☐***red*** ☐**other** _____

How much sputum do you produce over ***24 hours***?

☐ ***Less than 2 tablespoons*** ☐ ***More than 2 tablespoons***

Have you ever coughed up blood? ☐ **Yes** ☐ **No**
** If ***yes***, when and how much? _____

What, if anything, makes your cough ☐ **better** or ☐ **worse** ?
Is it improved after taking any particular medications? ☐ **Yes** ☐ **No**
If ***yes*, which ones? _____

Is it worse in any particular position (i.e.: lying down, bending over)?
_____
Is it worse after eating? ☐ **Yes** ☐ **No**

Is it worse with exposure to ☐ **dust** ☐ **fumes** ☐ **cold air** ☐ other_____
_____

Chest Pain:

Where exactly is the chest pain located (ie: front, back, left, right)? _____

When do you have chest pain?
☐ ***On exertion*** ☐ ***At rest*** ☐ ***After meals***

How long does the pain last?
☐ ***Few seconds*** ☐ ***5 minutes*** ☐ ***15 minutes*** ☐ ***1 hour*** ☐ ***All day***

How long have you had chest pain?
☐ ***Less than a year*** ☐ ***1 to 3 years*** ☐ ***More than 3 years***

Is the pain increasing in frequency or intensity? ☐ **Yes** ☐ **No**
What, if anything, makes the pain go away? ☐ ***Resting*** ☐***Eating*** ☐ ***Medication (list):***

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Past chest x-rays:

Location	Reason	Date (month/year)

Review of symptoms:

If you have had any of the following symptoms **recently**, please check all that apply:

General:

☐ fevers chills night sweats (enough to soak your shirt or sheets)
☐ weight loss/gain (how much? _____ In what amount of time? _____)

Head, eyes, ears, nose, throat:

☐ itchy/watery eyes hay fever
☐ post nasal drainage bleeding nose or gums
☐ sore throat hoarseness
☐ sinus congestion or drainage (color? _____)

Cardiovascular:

☐ shoulder or arm pain
☐ swelling in your legs
☐ shortness of breath when lying flat
☐ awakening at night short of breath

Pulmonary:

☐ Snoring ☐ insomnia ☐ daytime sleepiness ☐ legs twitches/discomfort

Gastrointestinal:

☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn
☐ reflux indigestion ☐ abdominal/stomach pain

Genitourinary:

☐ bloody urine ☐ painful urination ☐ trouble starting/stopping

Musculoskeletal:

☐ joint pain ☐ swelling muscle pain

Hematologic:

☐ easy bleeding ☐ bruising

Lymphatic: swelling of lymph nodes (Check one or more)

☐ under jaw ☐ on neck ☐ under arms ☐ in groin

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Skin: ☐ new rashes ☐ spots

Back: ☐ pain ☐ swelling

Neurological:

☐ headaches seizures ☐ passing out ☐ numbness/tingling in hands or feet

Past Medical History:

Please list any current or past medical illnesses and hospitalizations and the approximate dates:

_____
_____
_____

Please list all surgeries and approximate dates:

_____
_____

Medications (prescription and nonprescription)**:**

Name of medication	Dose	Times per day	Length of time used	Prescribing Physician

List **allergies** to:

Drugs: _____

Food: _____

Environment: _____

Social History:
Smoking history:

How many packs per day? _____ How many years have you smoked? _____

Have you smoked pipes or cigars? ____ When did you quit smoking? _____

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Exposure to secondhand smoke: ☐ never ☐ rarely ☐ occasionally ☐ often ☐ regularly

Number of alcoholic drinks per week: ____

Illicit drug use: ☐ marijuana ☐ cocaine ☐ narcotics ☐ Valium ☐ LSD ☐ IV drug use

Date of last flu shot: _____ Pneumovax: _____

Current occupation: _____

Previous occupations: _____

List any jobs, activities, or hobbies where you were routinely exposed to chemicals, powders, dusts, or other types of hazardous materials (i.e.: including asbestos, sandblasting and fumes)

Activity	Years of exposure	Type of hazardous exposure

Home environment in the last ten years. **Check** all that apply:

☐ Dog	☐ Livestock	☐ Old carpets	☐ Feather pillows
☐ Cat	☐ Horses	☐ Central air	☐ Indoor insect problem
☐ Bird	☐ Gas heat	☐ Old drapes	

Have you or anyone in your family had tuberculosis or a positive PPD skin test? ☐ **Yes** ☐ **No**
If **yes**, when and what treatment was given? _____

Please list any travel in the last 20 years

Outside of local region	Foreign
_____	_____
_____	_____
_____	_____
_____	_____

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Family History (include siblings, children and grandchildren; also make particular note of any diabetes, heart disease, strokes, hypertension, cancer, and asthma):

Family member	**Age**	**Medical Problem**	**Or**	**Age**	**Cause of Death**
Father					
Mother					
(Siblings)					
(Children)					

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Date: _____

SSN _____ Gender _____ Birth date _____ Marital Status _____

Name: _____
First Middle Last Preferred Name

Address: _____
Street City State Zip

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Ethnicity:

☐ Latino/Hispanic ☐ Asian ☐ Black/African American
☐ White ☐ Other ☐ Decline to Answer

Employment Status:

☐ Employed ☐ Disabled
☐ Self Employed ☐ Retired
☐ Unemployed ☐ Student

Employer Name: _____ Employer Phone #: _____

Preferred contact method for automated appointment reminders (select one or more):
☐ Voice (Home Phone) ☐ Text (Mobile Phone)
☐ Email ☐ Do Not Remind Me

Patient Portal Access (please select one):

☐ Please **email** an invitation to the patient portal. ☐ I decline access to the patient portal.

Referred By _____ Phone _____ Fax _____

Address: _____
Street City State Zip

Primary Care Physician _____ Phone _____ Fax _____

Address: _____
Street City State Zip

List other physicians you are currently seeing: _____

Are you currently residing in a skilled nursing facility? ☐ Yes ☐ No.

** If yes, name of facility _____

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Notify in case of emergency:

Name _____ Phone _____ Relationship _____

Address _____
Street City State Zip

Pharmacy _____ Phone _____

Have you signed a:

Living Will: ☐ Yes ☐ No

DNR (Do Not Resuscitate): ☐ Yes ☐ No (**Please provide a copy)

Durable Power of Attorney: ☐ Yes ☐ No Date Signed: _____ (**Please provide a copy)

Are you currently using a DME (Durable Medical Equipment) company? ☐ Yes ☐ No

If **yes**, which one? _____

If **no**, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab: _____ X-ray: _____

Is this a work-related illness/injury? ☐ Yes ☐ No

Date of illness/injury: _____ Date last worked: _____

Cause of accident if any _____

_____

I hereby authorize release of my medical records from _____ to **Tarrant Pulmonary Associates**. This authorization expires upon written notice from patient/patient representative.

_____ _____

Signature of Patient or Responsible Party Date

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