SLEEP & PULMONARY CARE CENTER
New Patient Information Form

Date: ____________________ Gender: ☐ Male ☐ Female
Patient Name: ____
Date of Birth: ____________________ Age: __________ SS #:__________________
Reason for Visit:____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Do you use tobacco? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes
If yes, how often? Rarely Occasionally/ 1-2 drinks per day >2 drinks per day
Do you use IV or illicit drugs? ☐ No ☐ Yes
Do you have exposure to birds or cats? ☐ No ☐ Yes

MEDICAL HISTORY - Do you have or have you had any of the following?

_____ Diabetes
_____ High Blood Pressure
_____ Coronary Heart Disease
_____ Glaucoma
_____ Shortness of Breath
_____ Congestive Heart Failure
_____ Heart Attack
_____ Emphysema or chronic bronchitis
_____ Wheezing
_____ High Cholesterol
_____ Chest Pain/Tightness
_____ Tuberculosis
_____ Thyroid Problem
_____ Cancer
_____ Depression/Anxiety
_____ Lung disease
_____ Asthma
_____ Kidney problems
_____ Daytime Sleepiness/Fatigue
_____ Restless legs
_____ Snoring
_____ Stroke
_____ Seasonal allergies
_____ Anemia
_____ Cough Blood
_____ Stroke

OTHER MEDICAL PROBLEMS

Are you on home oxygen? ☐ No ☐ Yes If yes, how many liters?______
Have you ever had a blood transfusion? ☐ No ☐ Yes If yes, when?______________

FAMILY HISTORY

Does your mother, father, brother(s) or sister(s) have any of the following?

Diabetes ☐ No ☐ Yes
High Blood Pressure ☐ No ☐ Yes
COPD ☐ No ☐ Yes
Coronary Artery Disease ☐ No ☐ Yes
Narcolepsy ☐ No ☐ Yes
High Cholesterol ☐ No ☐ Yes
Heart Problems ☐ No ☐ Yes
Lung Cancer ☐ No ☐ Yes
Sleep Apnea ☐ No ☐ Yes
Asthma ☐ No ☐ Yes

ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes
If yes, please list____

PAST SURGICAL HISTORY

Have you ever had surgery? If yes, please list below. ☐ No ☐ Yes

Are you currently on CPAP? If yes, what pressure? ☐ No ☐ Yes
Are you on Coumadin? ☐ No ☐ Yes Plavix? ☐ No ☐ Yes Aspirin? ☐ No ☐ Yes

Patient Signature____ **Date**____________________