PULMONARY ASSOCIATES, PA

New Patient Medical History Form

Name: _____ Date of Birth: _____
Date: _____ Referring Provider: _____Primary Care Provider: _____

Why are you seeing a pulmonary (lung) provider? _____
_____
_____

Have you recently been hospitalized: Yes No **When:** _____month/year **Where:**_____
Have you recently been in Urgent Care: Yes No **When:** _____month/year **Where:** _____

Have you recently had any of the following:

- ☐Chest X Ray **When:** _____month/year **Where:** _____
- ☐Chest CT (cat scan) **When:** _____month/year **Where:** _____
- ☐Echocardiogram **When:** _____month/year **Where:** _____

Have you had exposure to chemicals: Yes No **Type:** _____
Have you recently traveled outside of the country: Yes No **Where:** _____

Have you had Flu Vaccine(s): Yes No I do not wish to have vaccines
Please list the last 2: _____month/year, _____month/year

Have you had Pneumonia Vaccine(s): Yes No I do not wish to have vaccines
Which one and when: Prevnar 13 _____date, Pneumovax _____date

REVIEW OF SYMPTOMS

Please check any symptoms you are CURRENTLY experiencing below:

GENERAL

- ☐ **NONE**
- ☐ Fatigue (easily tired)
- ☐ Malaise (generally unwell)
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain

ENT

- ☐ **NONE**
- ☐ Earache
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Post Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat

RESPIRATORY

- ☐ **NONE**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Pain with Breathing
- ☐ Wheezing
- ☐ Known TB Exposure

CARDIOVASCULAR

- ☐ **NONE**
- ☐ Chest Pain
- ☐ Claudication (leg pain with activity)
- ☐ Edema (lower leg swelling)
- ☐ Palpitations
- ☐ Orthopnea (shortness of breath when lying down)

GASTROINTESTINAL

- ☐ **NONE**
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY

- ☐ **NONE**
- ☐ Increase in Urination
- ☐ Urination During the Night

PSYCHOLOGICAL

- ☐ **NONE**
- ☐ Anxiety
- ☐ Depression

DERMATOLOGIC

- ☐ **NONE**
- ☐ Hives
- ☐ Rash
- ☐ Itching
- ☐ Skin Lesions

NEUROLOGICAL

- ☐ **NONE**
- ☐ Dizziness
- ☐ Numbness in Hands/Feet
- ☐ Weakness in One/Both Arms/Legs
- ☐ Abnormal Gait (unusual walking)
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors

MUSCULOSKELETAL

- ☐ **NONE**
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness

HEMATOLOGIC/LYMPHATIC

- ☐ **NONE**
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Lymph nodes/glands

IMMUNOLOGIC

- ☐ **NONE**
- ☐ Seasonal Allergies
- ☐ Contact Allergies
- ☐ Food Allergies
- ☐ Inhalation Allergies

SLEEP

- ☐ **NONE**
- ☐ Insomnia
- ☐ Wake with Gasping/Choking
- ☐ Sleepiness During the Daytime
- ☐ Restless Sleep
- ☐ Snoring

PERSONAL MEDICAL HISTORY

PULMONARY
- ☐ Allergies
- ☐ Alpha 1 Antitrypsin
- ☐ Asbestosis
- ☐ Asthma
- ☐ Recurrent Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Nodule(s)
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Valley Fever (Coccidioidomycosis)

RHEUMATOLOGIC
- ☐ Lupus
- ☐ Rheumatoid Arthritis

CARDIOVASCULAR
- ☐ Anemia
- ☐ Atrial Fibrillation
- ☐ Blood Clots/DVT
- ☐ Chest Pain (Angina)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Elevated Cholesterol
- ☐ High Blood Pressure (HTN)
- ☐ Heart Attack (MI)
- ☐ Murmur/Heart Valve Disease
- ☐ Stroke

GASTROINTESTINAL
- ☐ Acid Reflux (GERD)
- ☐ Hepatitis, Type: C B A

GENITOURINARY
- ☐ Kidney Stones
- ☐ Chronic Kidney Disease

NEUROLOGIC/PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Insomnia
- ☐ Restless Leg Syndrome

METABOLIC
- ☐ Diabetes, Type: 1 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis

OTHER
- ☐ Cancer, Type: _____
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Immunoglobulin Deficiency

Additional Medical History _____

SURGICAL HISTORY

PULMONARY	YEAR
☐ Bronchoscopy	_____
☐ Lobectomy: L R	_____
☐ Lung Biopsy	_____
☐ Lung Surgery	_____
☐ Tonsillectomy	_____
☐ Adenoidectomy	_____
☐ Tracheostomy	_____
☐ Sinus Surgery	_____
CARDIOVASCULAR	_____
☐ CABG/Open Heart Surgery	_____
☐ Cardiac Catheterization	_____
☐ Cardiac Stent	_____
☐ Pacemaker	_____

GASTROINTESTINAL	YEAR
☐ Appendix Removal	_____
☐ Gall Bladder Removal	_____
☐ Gastric Bypass	_____
☐ Hernia Repair	_____
GENITOURINARY	_____
☐ Dialysis	_____
☐ Kidney Stone Removal	_____
☐ Kidney Removal	_____
MUSKULOSKELETAL	_____
☐ Back Surgery	_____
☐ Hip Replacement: L R	_____
☐ Knee Replacement: L R	_____
☐ Neck Surgery	_____
☐ Rotator Cuff Repair: L R	_____
	_____

FEMALE	YEAR
☐ C-Section (Cesarean)	_____
☐ Hysterectomy	_____
☐ Tubal Ligation	_____
MALE	_____
☐ Prostate Surgery	_____
OTHER	_____
☐ Cataract Surgery	_____
☐ LASIK	_____
☐ Lymph Node Biopsy	_____
☐ Mastectomy	_____
☐ Thyroidectomy	_____

Additional Surgical History _____

FAMILY HISTORY

☐ **No Significant Family History** ☐ **Adopted**

PULMONARY				
Alpha 1 Antitrypsin	☐ Father	☐ Mother	☐ Brother	☐ Sister
Asthma	☐ Father	☐ Mother	☐ Brother	☐ Sister
COPD	☐ Father	☐ Mother	☐ Brother	☐ Sister
Emphysema	☐ Father	☐ Mother	☐ Brother	☐ Sister
Pulmonary Fibrosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Pulmonary Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
Sarcoidosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Sleep Apnea	☐ Father	☐ Mother	☐ Brother	☐ Sister
CANCER				
Breast Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Colon Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Lung Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Other Cancer _____	☐ Father	☐ Mother	☐ Brother	☐ Sister
CARDIOVASCULAR				
Coronary Artery Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
Venous Thrombosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
RHEUMATOLOGIC				
Rheumatoid Arthritis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Lupus	☐ Father	☐ Mother	☐ Brother	☐ Sister
NEUROLOGICAL				
Alzheimer's	☐ Father	☐ Mother	☐ Brother	☐ Sister
Dementia	☐ Father	☐ Mother	☐ Brother	☐ Sister
ENDOCRINE				
Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister
SOCIAL				
Alcoholism	☐ Father	☐ Mother	☐ Brother	☐ Sister
Drug Abuse	☐ Father	☐ Mother	☐ Brother	☐ Sister

Additional Family History_____

SOCIAL HISTORY

Do you use Tobacco: Yes No Former **Type of Tobacco:** Cigarettes Cigar Pipe Chew Smokeless
Overall Daily Average: _____ pack(s)/pipe/can **Total # of Years Used:** _____ **Date Quit:**_____

Do you drink Alcohol: Yes No Former **Type of alcohol:** Beer Wine Liquor **How Much:**_____Beers/Glasses/Drinks
Date Quit: _____ **How Often:** Daily Weekly Monthly Yearly

Do you drink Caffeine: Yes No **Type of Caffeine:** Coffee Tea Soda Energy drinks **How Much:** _____cups/ounces

Do you use Recreational drugs: Yes No Former **Type:** _____ **How Often:** Daily Weekly Yearly **Date Quit:** _____

Do you Exercise: Yes No **Type of Exercise:** _____ **How Much:** _____ **How Often:** Daily Weekly Monthly

Occupation: _____ **Marital Status:** Single Married Life Partner Divorced Widowed
# of Years in Arizona _____ **Domestic Partner:** Opposite Sex Same Sex
# of Children: _____Sons _____Daughters **Pets:** Yes No **Type:** _____

PULMONARY ASSOCIATES

MEDICATION LIST

Name _____ Date of Birth _____ Date _____

Pharmacy _____ Location _____ Phone Number _(____)_____

Any **allergies** to medicines: Yes No Unknown

If Yes, what medicine(s): _____ What reaction(s): _____

_____ _____

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICINES, VITAMINS AND SUPPLEMENTS

Medication Name	Strength (mg, mcg, etc.)	How Often (1 x day, 2 x day, etc.)	Reason for taking (heart, blood pressure, etc.)

PAFORM #D
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PULMONARY ASSOCIATES

1112 E. McDowell Road
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Tel. 602.258.4951

9225 N. 3rd Street
Suite #205
Phoenix. AZ 85020
Tel. 602.258.4951

5750 W. Thunderbird Road
Building E500
Glendale, AZ 85306
Tel. 602.258.4951

5151 E. Broadway Road
Suite #107
Mesa, AZ 85206
Tel. 602.258.4951

10585 N. Tatum Blvd
Suite #D130
ParadiseValley, AZ 85253
Tel. 602.258.4951

1941 N. 27th Avenue
Suite #102
Phoenix, AZ 85027
Tel. 602.258.4951

Authorization to Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to release information regarding your care to the Family/Friend listed below. Please review, complete, sign & date and return to our front desk.
(Ex: prescription pick-up, appointment coordination, record retrieval, etc...)

Patient Name: _____ **Date Of Birth:** _____ **SSN #:**_____

I, _____, authorize Pulmonary Associates, PA to communicate with the person/persons listed below regarding my care and treatment.

1. _____ _____
Name **Address**
Telephone #: (_____) _____ _____ **85**_____
City/State **Zip Code**

2. _____ _____
Name **Address**
Telephone #: (_____) _____ _____ **85**_____
City/State **Zip Code**

___ Verbal Communication

___ Other (Please Specify): _____

The purpose of this release: COORDINATION OF CARE

Pulmonary Associates, PA is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time (in writing) with the exception that action has already been taken on the consent. Unless otherwise specified, this consent expires one year following date of signature.

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization of the release of medical or other Information for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." I understand records or information in the records will not be covered under Federal Privacy Laws should the RECEIPIENT of my records re-disclose them. Note: A photocopy and/or facsimile of this consent shall be considered valid as original.

_____ _____
Patient/Parent/Guardian Signature **Form to EXPIRE 1 year from original signed date**

Pulmonary Associates Office and Financial Policies:

Thank you for choosing Pulmonary Associates, PA. for your medical needs. We are committed to providing you with the highest quality medical care and maintaining a good physician-patient relationship is our primary goal. Even when insurance is in place, patients are ultimately responsible for charges associated with their care. As your provider, we feel it is our responsibility to let you know in advance of our office and financial policies. This will allow for a good flow of communication and enable us to achieve our physician-patient relationship goal. We realize you have choices for your medical care, and we sincerely appreciate you choosing Pulmonary Associates, PA.

For our patient's convenience, we participate in most major health plans. Our business office will submit claims for services rendered and will assist you in any reasonable way in getting your claims paid. It is the patient's responsibility to provide all necessary information during the appointment scheduling process as well as ensuring there is an authorization and/or referral form from your PCP if it is required by your insurance.

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

FEES AND SURCHARGES

- **$25.00 Fee for No Shows and Late Cancellations (cancelling with less than 24-hrs notice):**
  To avoid this fee, please call (602) 258-4951 to cancel or reschedule all appointments within 24 hours of your scheduled appointments. If you are not able to get through or call after business hours, please leave a voicemail of your cancellation.

- **$25.00 Fee for Form Completion:**
  There will be a fee of $25.00 for all forms needing completion outside an office visit.

- **FEES for Processing Medical Records Request Forms:**
  1-10 pages = $10.00
  11-20 pages = $15.00
  21+ pages = $25.00

- **Administrative Collection Fees:**
  Any outstanding balances sent to a third party collection agency will incur a 20% fee. In addition, you may not be able to make future appointments until this balance is discussed with our billing department.

- **$10.00 Surcharge Fee:**
  Your insurance requires you to pay your co-payment at the time of service. Failure to pay in full at the time of service will result in a $10.00 surcharge fee.

- **$25.00 NSF Fee for Returned Checks:**
  All returned checks will incur an additional $25.00 fee, and we will require alternative payment for all future visits.

Please SIGN and DATE below acknowledging your notification of these fees:

Print Name: _____

Signature: _____ **Date:** _____