PennState Health

New Patient Registration

Personal Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender (Please Check One): ☐ Male ☐ Female

Marital Status (Please One): ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Referring Physician: _____ Family Physician: _____

Other Specialists: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Local Pharmacy _____ Mail Order Pharmacy _____

Do you have a medical supply company (DME)? _____ If yes, who? _____

If yes, for what? ☐ Oxygen ☐ Nebulizer Machine ☐ CPAP/BiPAP ☐ Ventilator

New Patient Questionnaire

What brings you to our office today? _____

How long have you had this problem? _____

Have you seen a lung or sleep specialist in the past? _____ If yes, who? _____

Please check if you have had any of these tests done, please list where and when they were done.

- ☐ Pulmonary Function Test (Breathing tests): _____
- ☐ Chest X-Rays: _____
- ☐ CT Scan of Chest: _____
- ☐ Echocardiogram: _____
- ☐ Sleep Studies: _____

Patient's First and Last Name: _____ Date of Birth: _____

Past Medical History

Do you have any of the following health problems?

- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Asthma
- ☐ Cystic Fibrosis
- ☐ Pulmonary Fibrosis
- ☐ Pleural Effusion
- ☐ Asbestosis
- ☐ Lung Cancer
- ☐ Tuberculosis
- ☐ Pneumothorax
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Restless Leg Syndrome
- ☐ Sleep Apnea
- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Allergic Rhinitis
- ☐ Lupus
- ☐ High Cholesterol
- ☐ DVT (Blood Clots in Legs)
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Kidney Disease
- ☐ Atrial Fibrillation
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Acid Reflux
- ☐ Hypothyroidism
- ☐ Other Medical Conditions _____

_____

Allergies to Medications

Any allergies to medications? ☐ Yes ☐ No

If yes, please list: _____

_____

Surgical History

- ☐ Lung Surgery
- ☐ Cardiac Catheterization
- ☐ CABG (Bypass Surgery)
- ☐ Heart Valve Replacement
- ☐ Pacemaker/ICD Placement
- ☐ Tonsils and Adenoids
- ☐ Appendectomy
- ☐ Cholecystectomy (Gallbladder)
- ☐ Nasal Surgery
- ☐ Weight Loss Surgery
- ☐ Cataract Surgery
- ☐ Other surgeries- Please list: _____

Please list any hospital admission in the past 5 years. _____

_____

_____

Family History

List which relative (father, mother, or siblings) has any of the following conditions:

Lung Cancer	_____	Hypertension	_____
Emphysema	_____	Heart Disease	_____
Sleep Apnea	_____	Stroke	_____
Diabetes	_____	DVT/PE	_____
Narcolepsy	_____	Cancer	_____

Social History

Do you smoke or have you ever smoked? ☐ Never ☐ Current ☐ Former

If current or former smoker, how many years have you smoked? _____

If former smoker what year did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Do you use any recreational drugs? ☐ Yes ☐ No

If yes, which drugs? _____

Do you drink any caffeine? ☐ Yes ☐ No How many cups per day? _____

What is or was your occupation? _____

Have you had any prolonged exposure to the following?

☐ Asbestos ☐ Dust ☐ Fumes

☐ Cleaning Chemicals ☐ Steel Dust ☐ Tuberculosis

☐ Bird Exposure

Please list any animals/pets you have had? _____

Vaccines

Have you received any of the following vaccines?

Pneumococcal 23	☐ Yes	☐ No	When? _____
Prevnar 13	☐ Yes	☐ No	When? _____
Flu	☐ Yes	☐ No	When? _____

Patient's First and Last Name: _____ Date of Birth: _____

Medications

Please write or provide a list of ALL medications you are currently taking, including prescription, over-the-counter, vitamins, and inhalers.

	Medications	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Review of Systems

General	☐ Weight Loss	☐ Weight Gain	☐ Fever	☐ Fatigue	☐ Night sweats
Sleep	☐ Daytime fatigue	☐ Snoring	☐ Restless legs	☐ Non-refreshing Sleep	☐ Insomnia
ENT	☐ Post Nasal Drip	☐ Seasonal allergies	☐ Hoarseness	☐ Sinus Congestion	☐ Dry Mouth
Respiratory	☐ Shortness of Breath	☐ Coughing up Blood	☐ Wheezing	☐ Chronic Cough	☐ Sputum Production
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Dizziness	☐ Leg Swelling	☐ Irregular Heartbeat
Gastrointestinal	☐ Difficulty Swallowing	☐ Abdominal Pain	☐ Vomiting	☐ Reflux/Heartburn/Indigestion	☐ Blood in Stool
Genitourinary	☐ Frequent Urination	☐ Urgency	☐ Frequent Night time Urination	☐ Incontinence	☐ Blood in Urine
Hematology	☐ Lymph Gland Swelling	☐ Easy Bruising	☐ Cancer	☐ Blood Clots	☐ Anemia

Patient's First and Last Name: _____ Date of Birth: _____

STOP-BANG Questionnaire

1.	**S**noring- Do you snore loudly (loud enough to be heard through closed)?	YES	NO
2.	**T**ired- Do you often feel tired, fatigued, or sleepy during the daytime?	YES	NO
3.	**O**bserved Breathing Patterns- Has anyone observed you stop breathing during sleep?	YES	NO
4.	Blood **P**ressure- Are you being treated for high blood pressure?	YES	NO
5.	**B**MI- Body Mass Index more that 35kg/m^2?	YES	NO
6.	**A**ge- Are you over 50 years old?	YES	NO
7.	**N**eck Circumference- Is your neck size greater than 17" for men and 16" for women?	YES	NO
8.	**G**ender- Are you male?	YES	NO

Total *YES* Score _____

Epworth Sleepiness Scale

		Scoring Model
1.	Chance of dozing sitting and reading?	_____
2.	Chance of dozing watching TV?	_____
3.	Chance of dozing in an inactive public place? (i.e. movie theater, waiting room, meeting)?	_____
4.	Chance of dozing as a passenger in car for an hour without a break?	_____
5.	Chance of dozing if you lie down to rest in the afternoon.	_____
6.	Chance of dozing sitting and talking with someone?	_____
7.	Chance of dozing sitting quietly after lunch?	_____
8.	Chance of dozing while the car is stopped? (i.e. traffic or red light)	_____

Total _____

Please Use This Scale:

0- No Chance
1- Slight Chance
2- Moderate Chance
3- High Chance

Patient's First and Last Name: _____ Date of Birth: _____

Sleep Evaluation Patients Only

- ☐ I have been told I snore.
- ☐ I have been told I stop breathing when I sleep.
- ☐ I have high blood pressure.
- ☐ I have fallen asleep when I am driving.
- ☐ I get morning headaches.
- ☐ I suddenly wake up gasping of breath.
- ☐ I notice heart beating or pounding irregularly during the night.
- ☐ I am overweight.
- ☐ I often have difficulty falling asleep.
- ☐ I frequently wake with dry mouth.
- ☐ Thoughts race through my mind and prevent me from sleeping.
- ☐ I wake up earlier than I would like.
- ☐ I often feel like I am in a daze.
- ☐ I have experienced vivid like dreams.
- ☐ I have trouble at work because of sleepiness.
- ☐ I have fallen asleep in social setting like a party or movie.
- ☐ I have "sleep attacks" during the day no matter how hard I try to stay awake.
- ☐ I have episodes of feeling paralyzed during sleep or when awake.
- ☐ I have been told parts of my body jerk when I am asleep.
- ☐ I experience an aching or crawling sensation in my legs at night.
- ☐ Even though I slept during the night, I am sleepy during the day.
- ☐ I dream soon after I fall asleep or during naps

Signature

_____ _____

Signature of Patient or Authorized Representative Relationship to Patient

_____ _____

Signature of Practice Representative Title