PULMONARY PHYSICIANS
of norwich

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**Diseases of the Chest, Respiratory Tract, and Critical Care**

330 Washington Street, Suite 430 - Norwich, Connecticut 06360
**Phone:** (860) 886-1862 **Fax:** (860) 886-2046

123 Broadway - Colchester, Connecticut 06415
**Phone**: (860) 537-9108

558 Norwich Rd. – Plainfield, CT 06374

Dear _____,

Your appointment has been scheduled for _____ at _____ with _____ in the _____ office.

Enclosed you will find a Patient Demographic Sheet, General History Form and an Insurance Release Form. If you have been referred to our office for evaluation of a sleep disorder, there will also be a Sleep Questionnaire enclosed. Please complete **ALL** forms and bring them with you on the day of your scheduled appointment. Please arrive fifteen (15) minutes prior to your scheduled appointment. Also, please be sure to bring the following items with you the day of your visit, they will be **collected at check in:**

- **Photo ID**
- **Insurance Card(s)**
- **List of current medications (include dosage and instructions)**
- **List of allergies**
- **X-rays, CT Scan and/or MRI films**
- **Records from referring physician**
- **Workers Compensation must have date of injury, case number, case worker's name, phone number, and authorization at time of visit**
- **Copayment**

If your insurance requires a referral or Workers Compensation authorization, please be advised it is **your** responsibility to obtain one prior to your initial consultation as well as for all follow up appointments. If you do not have your referral or workmen's compensation authorization, you will be rescheduled at check in. **Co-pays** are due, in full, at time of service. We accept cash, check, or credit card. If you do not have insurance, please be advised that payment is due in full on the day of your appointment. **Our office reserves the right to charge $75.00 for appointments not kept or cancelled in less than 24 hours.**

If you have any questions regarding the information listed above, please feel free to call our office at (860)886-1862. Thank you for allowing us to participate in your care. We look forward to seeing you.

Sincerely,
Pulmonary Physicians of Norwich, P.C.

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Name: _____ DOB: _____ Today's Date: _____

**Personal Medical History**:

Describe the current medical problem/reason for today's visit: _____

_____

_____

**Are you currently experiencing any of the following?**

| | | |
|---|---|---|
| ☐ Chest pain/pressure/tightness | ☐ Heartburn/Acid Reflux | ☐ Snoring |
| ☐ Cough | ☐ Hemoptysis (coughing up blood) | ☐ Sudden weight loss or gain |
| ☐ Daytime Sleepiness | ☐ Insomnia | ☐ Syncope (fainting/passing out) |
| ☐ Difficulty hearing | ☐ Irregular heartbeat/palpitations | ☐ Visual Changes |
| ☐ Dizziness | ☐ Loss of Appetite | ☐ Vomiting |
| ☐ Environmental allergies | ☐ Memory Loss | ☐ Wheeze |
| ☐ Fatigue | ☐ Nasal Congestion | ☐ Other:_____ |
| ☐ Fevers/Chills/Sweats | ☐ Shortness of Breath | _____ |
| ☐ Headache | ☐ Skin irritation | _____ |

**Social History:**

Smoking Status: _____Smoker _____ Ex-smoker _____Never Smoked _____Second Hand Smoke Exposure

If smoker/smoked, what? _____Cigarette _____Pipe _____Cigars _____ Other: _____

Did you quit? Yes☐ No☐ When? _____ How long did you smoke? _____How much per day? _____

Do you drink alcohol? Yes☐ No☐ If yes, how many drinks per day? _____

Do you use recreational drugs? Yes☐ No☐ If yes, please specify: _____

Do you feel that you have a problem with alcohol or recreational drugs? _____

Have you traveled outside of the U.S.? Yes☐ No☐ If yes, where & when? _____

Have you ever been exposed to any hazardous materials in your work environment? Yes☐ No☐

If yes, what? _____

Do you have any pets? Yes☐ No☐ If yes, what? _____

**Immunizations**: (Please specify month/year received)

_____Influenza _____Pneumonia _____Pertussis/TDaP _____Varicella Zoster

**Preventative Care:** (Please specify month/year received)

_____Mammogram _____Pap-smear _____Colonoscopy

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Name: _____ DOB: _____ Today's Date: _____

**Surgical History:**

- ☐ No prior surgical history
- ☐ Appendectomy
- ☐ Endometrial Ablation
- ☐ Laparoscopy
- ☐ Breast Lumpectomy
- ☐ Gall Bladder
- ☐ Mastectomy
- ☐ Cataract Surgery
- ☐ Heart Surgery
- ☐ Myomectomy
- ☐ Colectomy
- ☐ Hemorrhoids
- ☐ Oophorectomy
- ☐ Cone Biopsy
- ☐ Hernia
- ☐ Tonsil/Adenoidectomy
- ☐ D&C
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Other:

_____
_____
_____
_____

Were there any complications during or after surgery? Yes ☐ No ☐ If yes, please specify:

_____

_____

Have you ever had any reactions to anesthesia? Yes ☐ No ☐ If yes, please specify:

_____

_____

**Hospitalizations:**

_____

_____

**Have you ever had or been diagnosed with any of the following?**

- ☐ Alcoholism
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bronchiectasis
- ☐ Cancer (Type: _____)
- ☐ Cardiac pacer/defibrillator
- ☐ Cerebrovascular accident/Stroke
- ☐ Chronic Renal Failure
- ☐ Chronic Respiratory Failure
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Congestive heart failure (CHF)
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Depression
- ☐ Diabetes Mellitus Type I
- ☐ Diabetes Mellitus Type II
- ☐ Epilepsy
- ☐ Gastric Ulcer
- ☐ Gastrointestinal Disease
- ☐ GERD
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Neurological Disorder
- ☐ Obesity
- ☐ Sleep Apnea
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Pneumothorax
- ☐ Prior Heart Attack
- ☐ Pulmonary Embolism
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Shingles
- ☐ Thyroid Disease
- ☐ TIA (Transient ischemic attack)
- ☐ Tuberculosis
- ☐ Other:_____

_____

_____

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Name: _____ DOB: _____ Today's Date: _____

**General Family History:**

___Adopted ___Unknown Maternal History ___Unknown Paternal History

| | Mother | Father | Maternal Grandfather | Maternal Grandmother | Paternal Grandfather | Paternal Grandmother | Siblings | Children |
|---|---|---|---|---|---|---|---|---|
| Asthma | | | | | | | | |
| COPD/Emphysema | | | | | | | | |
| Sarcoidosis | | | | | | | | |
| Cystic fibrosis | | | | | | | | |
| Alpha antitrypsin deficiency | | | | | | | | |
| Other Pulmonary Disease | | | | | | | | |
| Cancer (Type) | | | | | | | | |
| Heart attack/CAD | | | | | | | | |
| CHF | | | | | | | | |
| Hypertension | | | | | | | | |
| CVA/TIA/Stroke | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Other Heart Disease | | | | | | | | |
| Sleep Apnea | | | | | | | | |
| Other Sleep disorder | | | | | | | | |
| Bleeding Disorder | | | | | | | | |
| Anemia | | | | | | | | |
| Blood Clot (DVT/Pulmonary embolism) | | | | | | | | |
| Diabetes | | | | | | | | |
| Epilepsy/ Seizure | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Liver Disease | | | | | | | | |
| Thyroid disease | | | | | | | | |
| Mental Illness | | | | | | | | |
| | | | | | | | | |
| Age Deceased | | | | | | | | |
| Cause of Death | | | | | | | | |

**Additional family history not specified above:**

_____

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# Pulmonary Physicians of Norwich, P.C.

Please Print

Name: _____Date of Birth_____

Street Address: _____

Mailing Address (If different) _____

City: _____State:_____Zip:_____

Social Security Number: _____Sex:_____M_____F

Home Phone: _____ Cell Phone: _____ Other Phone:_____

Email Address: _____

Marital Status: __Married__Single__Widowed__Divorced__Partner__Fiance__Legally Seperated

Emergency Contact: _____Relationship_____Phone:_____

Ethnicity: ___Hispanic/Latino___Other Primary Language:_____

Race: ___American Indian or Alaskan Native ___Asian ___Black or African American

___ Native Hawaiian or Pacific Islander___ White

Primary Care Physician: _____ Phone Number:_____

Other physicians currently treating you:

Name: _____Specialty:_____Telephone:_____

Name: _____Specialty:_____Telephone:_____

Pharmacy & Town: _____

Allergies: _____

**Employer Information:**

Employer Name: _____Telephone: _____

Occupation: _____

**Insurance Information:**

Primary Insurance: _____ID#:_____

Card Holder:_____Relationship:_____

Secondary Insurance: _____ID#: _____

Card Holder:_____ Relationship:_____

If Workers Comp:

Company:_____ Claim #:_____

Date of Injury: _____Adjuster:_____Adjuster Phone: _____

Consent to obtain medication history via pharmacy: **YES** or **NO**