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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.



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?**

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Surgical History:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> No prior surgical history | <input type="checkbox"/> Heart Surgery        | <input type="checkbox"/> D&C            |
| <input type="checkbox"/> Appendectomy              | <input type="checkbox"/> Myomectomy           | <input type="checkbox"/> Hysterectomy   |
| <input type="checkbox"/> Endometrial Ablation      | <input type="checkbox"/> Colectomy            | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Laparoscopy               | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Breast Lumpectomy         | <input type="checkbox"/> Oophorectomy         | _____                                   |
| <input type="checkbox"/> Gall Bladder              | <input type="checkbox"/> Cone Biopsy          | _____                                   |
| <input type="checkbox"/> Mastectomy                | <input type="checkbox"/> Hernia               | _____                                   |
| <input type="checkbox"/> Cataract Surgery          | <input type="checkbox"/> Tonsil/Adenoidectomy | _____                                   |

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?**

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



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:**

\_\_\_\_\_



## 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 Separated

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**