National Jewish Health
Science Transforming Life

NATIONAL JEWISH SOUTH DENVER
NEW PATIENT INFORMATION

Welcome, so that we provide you with the best care possible, please assist us by completing the following form. Remember – always bring an updated list of all of your medications, including inhalers. (PLEASE PRINT CLEARLY)

Date:_____ **Name:**_____ **Birth Date:** _____ **Age:** _____**Sex: M F**

Primary Physician (required): _____

Other Physicians (to send information to): _____

MEDICATIONS

Please fill out form below or attach a detailed, legible, written list of all prescriptions, herbal remedies and over the counter medications you take on a regular basis. **Including the dose, route and frequency of administration.**

	Medication Name	Dose	Route (oral, inhale)	How often?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Medication Allergies

_____ Type of reaction: _____
_____ Type of reaction: _____
_____ Type of reaction: _____
_____ Type of reaction: _____

Have you ever had x-ray dye before? Y N
Are you allergic to x-ray dye? Y N If so, what type of reaction: _____

Preferred Retail Pharmacy _____

Address _____

Phone # _____ Fax # _____

Preferred Mail Order Pharmacy _____

Address _____

Phone # _____ Fax # _____

Preferred Laboratory (circle one) **Quest** **LabCorp** **Any**

OXYGEN

Oxygen Supplier _____

Continuous or pulse dose (conserver) system? _____

Compressed air (tanks) or Liquid ? _____

How many liters of oxygen?

Rest = _____ Activity = _____ Night = _____

CPAP/BiPAP/Ventilator Supplier _____

Mask type _____ Settings _____

Briefly describe the reason for your visit to National Jewish Health and what you hope to accomplish: _____

_____

Duration of symptoms: _____

Check any that apply:

Y N Cough (dry)
Y N Cough (phlegm)
Y N Cough (blood)
Y N Wheezing
Y N Congestion/Bronchitis
Y N Chest pain/Tightness/Pleurisy
Y N Shortness of breath at rest
Y N Shortness of breath with activity
Y N Shortness of breath at night
Y N Trouble breathing lying flat
Y N Increasing leg/ankle swelling/edema
Y N Weight loss/appetite change (unintentional)
Y N Trouble swallowing/choking
Y N Heartburn/Reflux
Y N Nasal congestion/Drainage/ Sinus Problems
Y N Fever/chills
Y N Night sweats
Y N Swollen glands

HPI/Notes:

_____
_____
_____
_____
_____
_____
_____

Check any history of:

Y N Asthma
Y N Emphysema
Y N Have you been tested for alpha-1 Antitrypsin deficiency?
Y N Chronic bronchitis
Y N Pneumonia
Y N Were you ever hospitalized for Pneumonia?
Y N Congestive heart failure
Y N Collapsed lung/Pneumothorax
Y N Blood Clot / Pulmonary embolism (lung or legs)
Y N Sleep apnea/Daytime fatigue
Y N Bronchiectasis
Y N Pulmonary fibrosis
Y N Lung cancer
Y N Sarcoidosis
Y N Arthritis/Lupus/Scleroderma
Y N Seasonal allergies
Y N Pulmonary hypertension
Y N Empyema
Y N Abnormal chest x-ray/CAT scan
Y N Exposure to Tuberculosis
Y N Positive TB skin test
Y N Whooping cough/Pertusis

_____
_____
_____
_____

PAST MEDICAL HISTORY (please list all of your current and past medical problems)

_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY (list year)

_____
_____
_____
_____
_____
_____
_____

Please list any recent hospitalizations within the last year (date, reason, which facility)

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Please list any diseases that have affected your family members. Please list any family history of emphysema, lung cancer, asthma, TB, blood clot lungs/legs, heart attack, diabetes, etc. Please also list the age they died.

Mother: _____
Father: _____
Brothers: _____
Sisters: _____
Maternal grandparents: _____
_____
Paternal grandparents: _____
_____

SOCIAL HISTORY

Marital Status: _____
Children: Y N Ages: _____

Residence:
Private Home Assisted Living Nursing Home

Have you ever smoked? Y N
For how long? Total # years: _____
Year quit: _____ Avg packs per day _____
Have you tried to quit? Y N
How? _____

Exposed to second hand smoke? Y N

Do you drink alcohol? Y N
How much? _____ How often? _____

Any past/present recreational drug use? Y N
Please describe: _____

Have you ever used diet pills? Y N

Do you exercise regularly? Y N
How often? _____ How long? _____

Are you exposed to any pets: dogs, cats, birds, rodents or wild animals? Y N
Please describe: _____

Occupation (current or previous):
_____

Have you ever worked in/with: __NONE
__Mine __Brick plant __Foundry
__Quarry __Pottery __ Cotton/flax/hemp mill

Have you ever been exposed to: __NONE
__Asbestos __Beryllium __Acids __Lead
__Solvents __Coal dust __Grinding dust

Do you have a hot tub? Y N
Humidifier? Y N Swamp cooler? Y N

Any recent foreign travel?
_____
_____
_____

Which of the following areas have you lived in?
__Arizona __California
__Ohio Valley __Southern States

Do you have any Advanced Directives?
__Living will __CPR directives
__Medical durable power of attorney

Vaccination/Immunization History	Date of Last Immunization Month / Year
Flu (Influenza) Shot	/
High Dose Flu Shot	/
Pneumovax (Pneumococcal Pneumonia)	/
Prevnar (Pneumococcal Pneumonia)	/

REVIEW OF SYSTEMS

Please mark all that apply:

GENERAL ☐ NONE
Fevers
Night sweats
Fatigue
Appetite loss
Recent weight changes

EYES ☐ NONE
Glaucoma
Cataracts
Macular degeneration

EAR/NOSE/THROAT ☐ NONE
Nasal congestion
Postnasal drip
Voice hoarseness
Sinus disease
Seasonal allergies

CARDIAC ☐ NONE
Heart attack (MI)
Valvular heart disease
Heart murmur
Rheumatic fever
Abnormal cholesterol
Congenital heart defect
Hypertension
Palpitations
Heart rhythm disorder
Pacemaker or cardiac defibrillator (ICD)
Claudication/leg pains
Passing out/syncope

SLEEP ☐ NONE
Morning headaches
Excessive daytime sleepiness
Excessive snoring
Restless sleep
Sleep disturbance secondary to breathing
CPAP/BiPAP use

GASTROINTESTINAL ☐ NONE
Heartburn/reflux
Difficulty/painful swallowing
Abdominal pain
Blood in stool or vomit
Nausea/vomiting
Colostomy/ileostomy
Hepatitis or jaundice

GENITOURINARY ☐ NONE
Painful urination
Frequent urination
Blood in urine
Incontinence/loss of bowel or bladder function
Frequent bladder/kidney infections
Enlarged prostate

GYNECOLOGICAL ☐ NONE
Are you presently or could you be pregnant? Y N
Abnormal mammogram
Abnormal Pap smear
Hysterectomy
Present of past history of cancer:
Breast Y N
Ovarian Y N
Uterine Y N

MUSCULOSKELETAL ☐ NONE
Osteoarthritis
Osteopenia/Osteoporosis
Rheumatoid arthritis
Fibromyalgia
Gout
Disc problems
Back pain
Trouble walking
Frequent falls
Pain in legs with walking
Joint pain (other than arthritis)
Bone pain

NEUROLOGICAL ☐ NONE
Fainting spells
Balance problems
Tremors
Dizziness
Seizures
Mini strokes/TIA
Stroke
Headaches/migraines
Muscle weakness
Memory problems
Difficulty swallowing
History of polio

BLOOD DISORDERS ☐ NONE
Anemia
Impaired immune system
Low platelets
Unusual bleeding
Blood clots (in legs or lungs)

ENDOCRINE ☐ NONE
Thyroid problems
Goiter
Graves disease
Diabetes

MENTAL/EMOTIONAL ☐ NONE
Excessive stress
Anxiety
Depression
Suicidal thoughts
Sleeping difficulty
Phobias (i.e. claustrophobia)

NOTES:

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Epworth Sleepiness Screening

Name: _____ Date of office visit: _____
Date of birth: _____

How likely are you to doze off or fall asleep in the following situations?

This refers to your usual way of life in recent times. If you have not done some of these things recently, try to estimate how they might have affected you.

Use the following scale to rate your chance of dozing in the following situations:

Score:
0 – Would never doze
1 – Slight chance of dozing
2 – Moderate chance of dozing
3 – High chance of dozing

Situations	Score
Sitting and reading	_____
Watching TV	_____
Sitting, inactive, in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	_____