For Office Use Only
Patient Acct #: ________

Metropolitan Pulmonary
Current Patient Information

Last Name: ______________________ First Name: ______________________ M.I.______

Address: ______________________ City: ______________ State: ______ Zip: ___________

Home #: ______________________ Work #: ______________________ Cell #:______________________

E-mail: ____

SSN: ______________________ Birthdate: ______________________

(Please circle): Gender: Female / Male
Marital Status: Single Married Widowed Divorced Separated
Ethnicity: Hispanic/Latino OR Not Hispanic/Latino
Race: American Indian / Alaska Native
Asian
Black / African American
White
Other

Primary Care Physician: ______________________ Referred By: ______________________

Emergency Contact: ______________________ Relation: ______________________

Phone #: ______________________

Communication Preference: ___ Home # ___ Work # ___ Cell # ___ E-mail

How would you like your statements sent to you? (Please circle) Paper or Electronic

Primary Insurance: ____

(If patient isn't the policy holder fill out this portion)
Policy Holder's Name: ______________________ Relation to Patient: ______________________

Policy Holder's D.O.B. ____________Policy Holder's SS # (For Tricare & Medicare insurance) ____________________

Secondary Insurance: ____

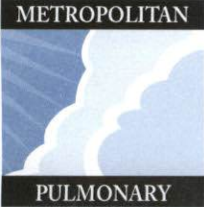
(If patient isn't the policy holder fill out this portion)
Policy Holder's Name: ______________________ Relation to Patient: ______________________

Policy Holder's D.O.B. ____________Policy Holder's SS # (For Tricare & Medicare insurance) ____________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize my health insurance carrier to pay benefits otherwise payable to me, directly to Metropolitan Pulmonary. I understand charges submitted to my insurance company by my physician or nurse practitioner may include charges for non-covered items or services. I agree that I will be responsible for charges not paid by my insurance company, including, but not limited to, charges applied to my deductible, non-covered or experimental services, co-insurance and copays.

____

Patient Signature *Date*



Name: ____________________ Date: __________

Reason for Visit: ____________________

Please List All Surgical Procedures:

Type of Surgery	Date Performed	Type of Surgery	Date Performed

Please list all current and past medical conditions e.g. high blood pressure.

____

____

____

____

____

Please list all current MEDICATIONS and their DOSAGES.

Medication	Dosage	Medication	Dosage

Please list all MEDICATION ALLERGIES and what reaction they cause.

Medication	Reaction

Family History

	Living	Deceased	Chronic Conditions or Cause of Death, if applicable.
Mother	❑	❑	
Father	❑	❑	
Sister	❑	❑	
Sister	❑	❑	
Brother	❑	❑	
Brother	❑	❑	

Social History

Have you ever smoked? ____________________

If so, when did you start? ____________________

If you have smoked, have you quit? When? ____________________

How many packs of cigarettes do / did you smoke daily? ❑ Less than 1 ❑ 1 ❑ 1$^1/_2$ ❑ 2 ❑ 2$^1/_2$ ❑ 3

Marital Status? ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

What is your occupation? ____________________

If retired, what were your main occupations? ____________________

How much alcohol do you drink in a week? ____________________

Review of systems: Please check all that apply to your CURRENT health

GENERAL

- ❑ Loss of appetite
- ❑ Fevers
- ❑ Night sweats
- ❑ Chills
- ❑ Nausea
- ❑ Vomiting
- ❑ Unintentional weight loss (in past 12 months)
- ❑ Weight gain (in past 12 months)

GASTROINTESTINAL

When was your last colonoscopy? ____________

- ❑ Difficulty swallowing
- ❑ Heartburn/reflux
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stools
- ❑ Abdominal pain
- ❑ Liver or gallbladder disease

HEMATOLOGIC

- ❑ Anemia
- ❑ Blood clots
- ❑ Nosebleeds

CARDIOVASCULAR

- ❑ Chest pain/angina
- ❑ Heart murmur
- ❑ Irregular heart rhythm
- ❑ Leg swelling
- ❑ Chest pain when walking
- ❑ Shortness of breath that wakes you

HEAD / EYES / EARS / NOSE / THROAT

- ❑ Headaches
- ❑ Glaucoma
- ❑ Retinopathy
- ❑ Hearing loss
- ❑ Allergies

GENITOURINARY

- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Urinary tract infections
- ❑ Enlarged prostate
- ❑ Kidney stones

SKIN

- ❑ Rash
- ❑ Skin cancer

NEUROLOGIC

- ❑ Numbness
- ❑ Paralysis
- ❑ Seizures
- ❑ Blackouts
- ❑ Vertigo/dizziness
- ❑ Neuropathy

MUSCULOSKELETAL

- ❑ Arthritis
- ❑ Backache
- ❑ Osteoporosis

PSYCHIATRIC

- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar affective disorder

SLEEP

- ❑ Insomnia
- ❑ Snoring
- ❑ Unrefreshing sleep
- ❑ Daytime sleepiness

MISCELLANEOUS

- ❑ Exposure to tuberculosis
- ❑ Positive PPD skin test

Please List All Chest X-ray & CT scans that you have had in the past:

Chest X-ray/ CT scan	Location	Date Performed
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

What pets do you have & how many?

Cats ________ Dogs ________ Birds ________ Other ______________________

Other Exposures: Please Check All That Apply

____ Birds
____ Bat droppings
____ Woodworking
____ Stained glass making
____ Hot tubs
____ Industrial paint
____ Asbestosis
____ None

Medication Exposures: Please Check All That Apply

____ Amiodarone
____ Diet medication such as Fen/phen (Fenfluramine/phentermine)
____ Methotrexate
____ HCTZ (Hydrochlorothiazide)
____ Macrodantin / Macrobid / Nitrofurantoin
____ None