Respiratory Specialists
Chesmont Professional Building
13 Armand Hammer Boulevard
Suite 300
Pottstown, Pa. 19464
(610) 685-LUNG (5864) or 800-521-4732
Fax: (610)-929-1528
WWW.LUNGMD.NET

WELCOME,

On behalf of the Physicians and staff of Respiratory Specialists, we would like to welcome you to our practice. We specialize in the diagnosis and treatment of the lungs, sleep, and allergy disorders.

PLEASE BE SURE TO READ THIS ENTIRE LETTER AS IT CONTAINS IMPORTANT INFORMATION ABOUT YOUR FIRST VISIT TO OUR PRACTICE.

In order to best prepare you for your first visit, we would like to familiarize you with some of our office policies and procedures.

Please complete and bring in the enclosed forms to your appointment. Please do not mail these forms to the office.

- **Bring all of your health insurance cards to be photocopied for your office record. Please notify your DME provider, if you have one, with the name of the specialist you are seeing so we can download your smartcard information upon arrival.**
- **If your insurance company requires an electronic or paper referral, please obtain one from your primary doctor prior to your appointment.**
  (If a referral is required and you arrive for your visit without one, you will be asked to reschedule)
- If you have had any chest X-rays and/or CT scans from any facility other than Reading Hospital or St. Joseph Medical Center please ask that facility to put them on a disc and bring that disc with you to your office visit.
- Bring in a list of **ALL** your current medications.
- ***PLEASE DO NOT WEAR COLOGNE OR PERFUME TO YOUR APPOINTMENT.***

Your appointment is scheduled with

Date: N DShort Report to office Time: --:--

***Please be advised your appointment is in our Pottstown Office ***

In addition to completing the attached forms, please access our Patient Portal using the attached activation letter and complete your medical history.

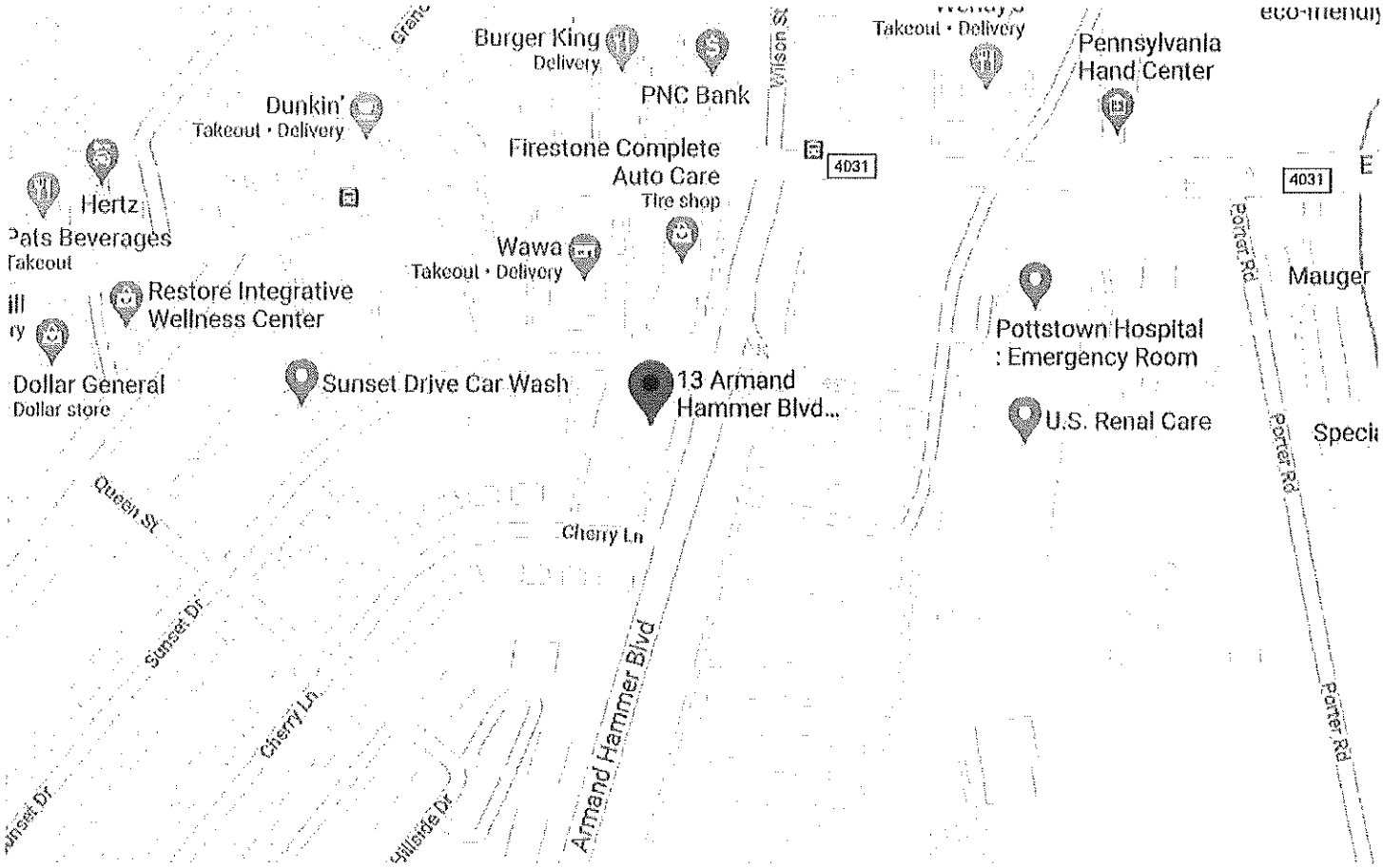
Please note your appointment date and time. Depending upon your contact information you gave us when scheduling your appointment you may receive reminders by e-mail 4 days prior to your appointment, cell phone text message 5 days prior to your appointment and/or a phone call 6 days prior to your appointment. You will be given an opportunity with each of those notices to either confirm or ask to be rescheduled. If for any reason you cannot keep your appointment, please notify our office at least 24 hours in advance. If you fail to provide notice, there may be $30.00 charge for any cancellations, rescheduled or no show appointment that have not been cancelled with at least 24 hours notice unless otherwise determined by Administration for extenuating circumstances.

If you do not have your co-pay at the time of your appointment, you will be rescheduled.

We appreciate you choosing Respiratory Specialists for your health care needs and look forward to meeting you.

Sincerely,
Berks Schuylkill Respiratory Specialists

If you need an interpreter it is YOUR responsibility to bring them to your appointment.


Burger King
Delivery
PNC Bank
Takeout • Delivery
Pennsylvania
Hand Center
Dunkin'
Takeout • Delivery
Firestone Complete
Auto Care
Tire shop
4031
Hertz
Wawa
Takeout • Delivery
Restore Integrative
Wellness Center
Pottstown Hospital
: Emergency Room
Dollar General
Dollar store
Sunset Drive Car Wash
13 Armand
Hammer Blvd...
U.S. Renal Care
Queen St
Cherry Ln
Sunset Dr
Armand Hammer Blvd
Porter Rd
Hillside Dr

New Patient Questionnaire **Respiratory Specialists**

Patients Name: _____ Date: _____

Age: Age Date of Birth: ____/____/_____

Primary Care Physician: _____

What is the nature of the problem that brought you to the office:

_____

_____

_____

_____

Name of Emergency Contact: _____
Relationship:_____
Phone: _____

Past Medical History (check each condition that applies)

☐Lung Disease	☐Sleep Apnea	☐ Heart Disease	☐High Cholesterol
☐Asthma	☐Insomnia	☐ Hypertension	☐Thyroid Disease
☐COPD	☐Restless Leg	☐ Angioplasty/Stents	☐Diabetes
☐Emphysema	☐Recurrent Sinusitis	☐ Heart Failure	☐HIV
☐Chronic Bronchitis	☐Lung Cancer	☐ Stroke	☐Hepatitis
☐Tuberculosis	☐Other Cancer	☐ DVT/Blood Clot	☐Lupus
☐Sarcoidosis	☐Allergies	☐ Pulmonary Emboli	☐Rheumatoid Arthritis
☐Pneumonia	☐Fibromyalgia	☐ Kidney Disease	

Please List All Other Major Illnesses:

_____

_____

_____

_____

Please List All Operations and Dates:

_____

_____

_____

_____

Have you been admitted to the Hospital in the Last Two Years?
Date___ / ___ / ____Where_____Reason_____
Date___ / ___ / ____Where_____Reason_____
Date___ / ___ / ____Where_____Reason_____
Date___ / ___ / ____Where_____Reason_____

DME Equipment (Check appropriate answer)

☐Oxygen ☐ Nebulizer ☐CPAP/BiPAP
Supplier _____

Name:_____ **Date:** _____

Health History (circle appropriate answer)

Sex: ☐ Female ☐ Male Height: _____ ft _____ in Weight: _____ lbs

Please rate your current health status: ☐ poor ☐ average ☐ good ☐ excellent

Do you currently smoke? ☐ Yes ☐ No How long? (years) _____ How many packs a day? _____

Did you smoke? ☐Yes ☐ No How long did you smoke? (years) _____When did you stop? _____

How many packs per day? _____ Why did you stop? _____

Do you have pets such as dogs, cats, or birds? Yes No If "Yes" type and #_____

Please rate your current energy level: ☐ poor ☐ average ☐ good ☐ excellent

Do you snore: ☐ Yes ☐ No Do you experience daytime drowsiness? ☐ Yes ☐ No

Do you feel rested in the morning? ☐ Yes ☐ No

How often do you exercise? ☐ Never ☐ occasionally ☐ regularly ☐ frequently ☐ daily

Have you gained weight over the last 5 years? ☐ Yes ☐ No If "yes" how many pounds?_____

Have you lost weight over the last 5 years? ☐ Yes ☐ No If "yes" how many pounds?_____

Alcohol Consumption: _____ # of drinks per ☐ day ☐ week ☐ month ☐ year

Occupation History:

Current: _____
Former: _____
If Retired: (when) _____
If Disabled: (when/why) _____
Any Toxin Exposure? (Asbestos, Beryllium, Lead, Coal Dust, Silica or Other) _____

Family History

Relationship	Age	Medical Problems (please list)	Deceased?_____
Father			
Mother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Spouse/Partner			

Name: _____ Date: _____

MEDICATIONS

Please list all your medications below and bring bottles with you to your first appointment
*include inhalers, nebulizer solutions over-the-counter, vitamins and health supplements.

Medications	**Dosage**	**Times per Day**

ALLERGIES TO MEDICATIONS

Medication	Reaction

VACCINATIONS

Type	If YES What Year
Flu	
Pneumonia or Pneumovax	
Hepatitis	

Name: _____ **Date:** _____

REVIEW OF SYSTEMS *(Check those symptoms that YOU experience)*

CONSTITUTIONAL:
- ☐ Change in weight
- ☐ Fever/chills
- ☐ Night sweats

RESPIRATORY:
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma/wheezing
- ☐ Dust inhalation

CARDIAC:
- ☐ Chest pain
- ☐ Shortness of breath on reclining
- ☐ Wake up short of breath
- ☐ Racing/irregular heart beat
- ☐ Blackout spells
- ☐ Ankle swelling
- ☐ Aching legs when walking

ALLERGIC:
- ☐ Allergies to dust, pollen, animals
- ☐ Seasonal hay fever
- ☐ Feathered Pillows

FOOD ALLERGIES
- ☐ Milk
- ☐ Nuts
- ☐ Shellfish
- ☐ Seafood

ENVIRONMENTAL ALLERGIES
- ☐ Pets
- ☐ Odors
- ☐ Insects
- ☐ Bee stings
- ☐ Weather
- ☐ Grass

SLEEP:
- ☐ Excessive sleepiness
- ☐ Insomnia
- ☐ Loud snoring
- ☐ Breath stop at night
- ☐ Leg pain at night

GASTROINTESTINAL:
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Yellow jaundice
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Hernia
- ☐ Hemorrhoids

GENITOURINARY:
- ☐ Burning on urination
- ☐ Nighttime urination
- ☐ Blood in urine
- ☐ Change in urine stream

EYES,EARS,NOSE,THROAT:
- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Frequent bloody nose
- ☐ Hoarseness
- ☐ Changes in vision
- ☐ Double vision

NEUROLOGICAL:
- ☐ Frequent/severe headache
- ☐ Numbness/tingling
- ☐ Uncoordination
- ☐ Weakness
- ☐ Seizures

SKIN:
- ☐ Itching
- ☐ Rash
- ☐ Change in mole
- ☐ Breast pain/lump
- ☐ New lumps

ENDOCRINE:
- ☐ Heat/cold intolerance
- ☐ Neck irradiation
- ☐ Excessive thirst
- ☐ Unusual dietary cravings

HEMATOLOGICAL:
- ☐ Enlarged lymph nodes
- ☐ Excessive bleeding/bruising
- ☐ Blood clots

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Back pain

I have personally reviewed the past medical history, DME, health history, medications, allergies, social history, family history, and review of system during this visit.

Patient Physician Clinical Staff Member Date

Respiratory Specialists

Tel: 610-685-5864 Fax: 610-929-1528

Name: _____ Date: _____

Part 1

In order to help diagnose and treat you, please take time to complete this questionnaire prior to your appointment. Check the block that best applies to you and bring the completed form to the office.

	Always	Freq.	Occ.	Never
I am told I snore.	☐	☐	☐	☐
I am told I stop breathing while I sleep.	☐	☐	☐	☐
I wake up choking or gasping.	☐	☐	☐	☐
I fall asleep when I don't want to.	☐	☐	☐	☐
I fall asleep when I am driving.	☐	☐	☐	☐
I have headaches in the morning.	☐	☐	☐	☐
I take a nap every day.	☐	☐	☐	☐
I frequently awaken with a dry mouth.	☐	☐	☐	☐
I have difficulty concentrating.	☐	☐	☐	☐
I wish I had more energy.	☐	☐	☐	☐
I feel like I am going around in a daze.	☐	☐	☐	☐
I feel sleepy during the day even though I slept through the night.	☐	☐	☐	☐
I have trouble at work because of sleepiness.	☐	☐	☐	☐
I sweat excessively at night.	☐	☐	☐	☐
I feel my heart pounding during the night.	☐	☐	☐	☐
I have high blood pressure.	☐	☐	☐	☐
I have to get up to go to the bathroom more than once a night.	☐	☐	☐	☐
I "wet" the bed.	☐	☐	☐	☐
I drink at least three caffeinated beverages every day.	☐	☐	☐	☐
I drink caffeinated beverages every evening.	☐	☐	☐	☐
I am losing my sex drive.	☐	☐	☐	☐
I feel muscle tension in my legs other than when I am exercising.	☐	☐	☐	☐
I have noticed that part of my body jerks at night.	☐	☐	☐	☐
I have leg pain or cramps at night.	☐	☐	☐	☐
I awaken with sore muscles.	☐	☐	☐	☐
I experience vivid dream like scenes soon after falling asleep.	☐	☐	☐	☐
I have episodes of feeling unable to move after falling asleep.	☐	☐	☐	☐
I fall asleep at social settings like parties or restaurants.	☐	☐	☐	☐
My muscles go limp when I laugh, get mad, or get startled.	☐	☐	☐	☐
I find naps refreshing.	☐	☐	☐	☐
I take longer than 30 minutes to fall asleep.	☐	☐	☐	☐
I often wake up during the night and have trouble falling back to sleep.	☐	☐	☐	☐
I am sleepy before bed, but not when I go to bed.	☐	☐	☐	☐
I have thoughts racing through my head when I try to go to sleep.	☐	☐	☐	☐
I wake up for unknown reasons and I have trouble going back to sleep.	☐	☐	☐	☐
I get frustrated and/or anxious when I can't fall asleep.	☐	☐	☐	☐
I need medication or alcohol to help me sleep at night.	☐	☐	☐	☐

Name: _____ Date: _____

Part 2

Please answer the following questions:
I usually go to bed at _____
I usually wake at _____
I work day shift, evening shift, night shift. _____
Rotate shifts or not applicable _____
My neck collar size is _____
My highest weight in high school was_____
My weight 5 years ago was _____
My weight 1 year ago was _____

EPWORTH SLEEPINESS SCALE

Patient Name:_____ Date:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

Reference: Johns, M.W. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991; 14:540-5.