SALEM CHEST SPECIALISTS

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3001 LYNDHURST AVE
WINSTON SALEM, NC 27103
Phone: (336) 765-0383
Fax: (336) 768-1737

Name:
Date of Birth:

Date:
Primary Care MD:
Date last seen by above MD:____________________

Please list the names of Physicians/Specialists you routinely see/ have seen in past:

____

____

____

Please answer the following?:

Current Smoker: number of year(s) _______ pack(s) per day ________
Former Smoker: number of year(s) _______ pack(s) per day _______ year quit ________
Never Smoked? Y or N

Alcohol Use? Y or N
If yes, how much?: ____

Illicit Drug Use? Y or N
If yes, please specify: ____

Caffeine Use? Y or N (soda, coffee, tea)
If yes, how much?: ____

Occupation? Full Time, Part Time, or Retired
What is/was your type of work?: ____

Marital Status?: Single, Married, Divorced, or Widowed

Pets? Y or N
If yes, please specify?: ____

List serious illnesses, surgical operations, hospitalizations in the past with dates:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

	Age	Disease	(W)ell(S)ick(D)ead		Age	Disease	(W)ell(S)ick(D)ead
Father				Sibling M F			
Mother				Spouse M F			
Sibling M F				Child M F			
Sibling M F				Child M F			
Sibling M F				Child M F			

Circle if any blood relative had:

1. Asthma
2. Emphysema
3. Lung cancer
4. Colon cancer
5. Ovarian cancer
6. Breast cancer
7. Heart disease
8. Stroke
9. Tuberculosis
10. Diabetes
11. Cystic Fibrosis

Salem Chest Specialists
Review of Systems

Constitutional

Fever ________
Chills ________
Weight loss_____
Fatigue_______
Sweats ________
Weakness_____

Skin

Rash _________
Itching ________

HEENT

Headache______
Hearing loss____
Ear ringing _____
Ear pain _______
Nosebleed _____
Congestion_____
Stridor ________
Sore throat _____

Eyes

Blurred vision _____
Double vision ______
Pain with bright light ______
Eye pain ___________
Discharge _________
Redness ___________

Cardiovascular

Chest pain ________
Palpitations ______
SOB lying flat _____
Cramping legs with exertion ________
Leg swelling ______
SOB walking ______

Respiratory

Cough ___________
Cough blood ______
Sputum _________
Shortness of breath __________
Wheezing ________

GI

Heartburn _______
Nausea __________
Vomiting ________
Abdominal pain _________
Diarrhea ________
Constipation _____
Blood in stool _____
Black tarry stool __________

GU

Pain with urination __________
Urgency _________
Frequency _______
Bloody urine ____
Flank pain _______

Musculoskeletal

Muscle pain ______
Neck pain _______
Back pain _______
Joint pain _______
History of falls ____

Heme/Allergy

Easy bruising _______
Allergy symptoms ____
Thirst ______________

Neurological

Dizziness __________
Tingling ___________
Tremor ___________
Sensory change _____
Speech change _____
Focal weakness _____
Seizure ___________
Loss of consciousness ___________

Psychiatric

Depression _________
Suicidal thoughts ____
Substance abuse _____
Hallucinations ______
Anxiety ____________
Insomnia ___________
Memory loss ________

Patient Name: ______________________________ Date: ______________

SLEEP FACTS

Do you have a history of snoring?

- o Never
- o Sometimes— occasionally or under special circumstances
- o Every night or almost every night
- o Do not know

Has your bed partner ever moved, temporarily or permanently, to another bedroom (or had you move to another bedroom) due to snoring or restless sleep?

- o Yes
- o No

Have you ever been told you seem to have momentary periods of sleep when you stop breathing or breathe abnormally?

- o Yes
- o No

Do you ever gasp for air during the night?

- o Yes
- o No

Have you ever been told you kick during your sleep?

- o Yes
- o No

Do you have a family history of sleep apnea?

- o Yes
- o No

How sleepy are you now on a scale of 1 — 10?
Please circle the number (1 = not sleepy and 10 = very sleepy)

1 2 3 4 5 6 7 8 9 10

Epworth Sleepiness Scale

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: (0 — 3)
Sitting and Reading	________
Watching TV	________
Sitting inactive in a public place (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 lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
Total Score (add up the numbers) **This is your Epworth Score:**	________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Salem Chest Specialists Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the following restrictions:

____

____

With whom we may discuss your treatment other than your physicians?

Name: ______________________ *Relationship:* ______________ *Phone:* ____________

Name: ______________________ *Relationship:* ______________ *Phone:* ____________

With whom may we discuss your payment (if different from above)?

Name(s): ____

Signature: __________________________________ **Date:** ____________________

If not signed by patient, please indicate relationship to patient:

Relationship: ________________________ *Witnessed by:* ________________________

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: ________________________________ ____________

Date *Time*

By: ____

Name and Title