Name_____DOB_____

SUBURBAN PULMONARY MEDICINE, P.C.

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196 WEST SPROUL ROAD, SUITE 207
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As a new patient, we would like you to print and complete the following pages before your upcoming appointment with us.

Please bring the following to your appointment:

- Insurance cards
- Referral if needed
- Co-pay for the office visit (We accept cash or check only!)
- Records such as x-rays, CT scans, pet scans (we need the actual films if not done at Crozer Chester Medical Center, Taylor Hospital or Springfield Hospital), & lab work
- List medications on sheet provided with dosage including inhalers, oxygen & nebulizer
- Complete list of all physicians that care for you

Thank you for your cooperation.

Suburban Pulmonary Medicine

Name_____DOB_____

New Patient Questionnaire Packet

The following pages contain important questions that will assist us in providing the best care possible.

Reason for Visit/Current Visit:

Referred by:

Other Physicians involved in care:

Pharmacy:

Tobacco use: **Cigarettes** Y N **Amount:** _____ **Age from** _____ **to** _____

Other: Please list:

Alcohol: **Amount per week:** _____ **Product:** _____

Medications including Inhalers:

Oxygen/CPAP/BIPAP:

Allergies:

Family History (Focus on Lung conditions, Allergic conditions, Heart conditions, and any cancers)

Parents: **Father** **Mother**

Name_____DOB_____

Siblings:

Children:

Past Medical History:

Current Medical Conditions:

Recent Hospitalizations/Surgeries:

Lab Work:

X-Rays/CT Scans/PET Scans:

Name_____DOB_____

Breathing Tests:

Other:

PLEASE BE COMPLETE.

Occupational History: Please list all jobs, types of work since completion of school.

Please add any additional comments or information you believe is helpful.

Current Problems: CHECK IF YES

General **N/A**_____	_____ Wt Loss _____ Wt Gain _____ How Much? _____ Fatigue _____ Malaise _____ Weakness _____ Loss of Appetite _____ Pain
Eyes **N/A**_____	_____Vision Loss _____ Blurring _____ Irritation
Nose **N/A**_____	_____ Discharge _____ Bleeding _____ Sinus Problems
Throat **N/A**_____	_____ Sore _____ Swallowing Problem _____ Voice Change
Heart **N/A**_____	_____ High Blood Pressure _____ Tightness _____ Edema/Swelling _____ Irregular Heartbeat/Palpitations _____ Murmur _____ Pain

Name_____DOB_____

Lungs **N/A_____**	_____ Cough _____ Infections _____ Fever _____ Snoring _____ Sputum (Color) _____ Blood _____ Shortness of Breath _____ Wheeze _____ Asthma _____ Sleep Impairment _____ Pain
GI **N/A_____**	_____ Heartburn _____ Constipation _____ Bleeding _____ Diarrhea _____ Ulcers _____ Infection _____ Other
Kidneys **N/A_____**	_____ Pain _____ Infection _____ Stones _____ Other
Musculoskeletal **N/A_____**	_____ Arthritis _____ Pain _____ Osteoporosis _____ Surgery
Skin **N/A_____**	_____ Cancer _____ Bruising _____ Rash
Nervous System **N/A_____**	_____ Headache _____ Stroke _____ Seizure _____ Numbness
Mental **N/A_____**	_____ Anxiety _____ Depression _____ Bipolar _____ Addiction
Endocrine **N/A_____**	_____ Diabetes _____ Thyroid Disease _____ Other
Blood **N/A_____**	_____ Anemia _____ Malignancy _____ Clots

Name_____DOB_____

Allergies **N/A_____**	_____ Seasonal _____ Medications _____ Food _____ Other
Infections **N/A_____**	_____ HIV _____ Chronic _____ Other