ROCKY MOUNTAIN PULMONOLOGY
an *Affiliate* of Mountain View Hospital

PATIENT INFORMATION

Name: _____ Date of Birth: _____Date:_____

Street Address: _____

Mailing Address (PO Box): _____
City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____
Race: _____

Ethnicity: (Circle one)

Hispanic/Latino Not Hispanic/Latino Declined to Specify/unknown Other

Social Security # _____ Preferred Language: _____

Patient's Employer:

_____

Primary Care Provider: _____
Referring Provider: _____

Insurance Information

Primary: _____

Employer's Name: _____

ID #: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Secondary: _____

ID #: _____ Group #:_____

Subscriber's Name: _____ Date of Birth: _____

Workers' Compensation: YES NO Date of Injury: _____

Employer: _____ Case#: _____

Insurance Carrier_____WCB#:_____

Emergency Contact Person

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

MEDICAL HISTORY

Referral

Please describe, in your own words, the problem for which you have been referred for evaluation:

_____

_____

Respiratory Questionnaire

Symptom	Yes	No	Morning	Day	Night	Occur in attacks	Worse with exertion	Number of years
Cough								
Mucous								
Wheeze								
Shortness of breath								
Bloody Sputum								

What is your current Height: _____ Weight: _____

Date of last TB test: _____Date of last flu shot: _____Date of pneumovax: _____

List major health / diseases for which you have received treatment:

_____

_____

_____

List the surgeries you have had, either as an in-patient or an out-patient:

_____

_____

_____

List all serious injuries from accidents:

_____

_____

List your current medications, dosages, and how many times per day you take them:

Name	Dosage	Frequency

What pharmacy do you currently use and location? _____

List all allergies to medications with reactions:

_____

_____

List your allergies to other environmental substances (i.e., cats, dust, etc.):

_____

FAMILY HISTORY

(Please list major illnesses of family members)

	Living **Yes / No**	**Age:** **Living / at Death**	**Major Illnesses**
Mother			
Father			
Brothers			
Sisters			
Children			

Do you have a healthcare proxy or MOLST/DNR form? YES NO
If so, please bring to appointment with you.

SOCIAL HISTORY

Tobacco Use

Do you smoke? YES NO

If YES, What? _____ How much per day? _____ How many years? _____

If NO:

Did you smoke in the past? _____What? _____ How many per day? _____

How many years? _____ When did you quit? _____

Have you used smokeless tobacco? YES NO

If YES:

How much per week? _____ How many years? _____Are you still using? YES NO

Have you ever used street drugs (marijuana, cocaine, heroin, etc.)? YES NO

Alcohol Use

Do you drink alcohol? YES NO

What type? _____ How many per day/month? _____

OCCUPATION: Please list the jobs that you have had since you first started working, as well as the time frame of employment. Please include any time spent in military service.

Dates	**Employer name or product / service**	**Job title / duties**	**Major exposures (dust, chemicals, etc.)**	**Protective equipment (dust masks etc.)**

ENVIRONMENTAL EXPOSURES

Do you have:

Carpeting - YES NO Feather pillows - YES NO Finished basement - YES NO

Type of home heating system: _____

Number of persons currently living in your household: _____

List what type(s) of pets / outdoor animals with which you have contact:

_____

Have you been exposed to talc / asbestos? YES NO

Do you have hobbies involving dust / chemicals?

YES NO

Have you been in a fire or worked as a fire fighter? YES NO

REVIEW OF SYSTEMS

(Please circle any symptoms that you have experienced within the past 12 months):

Constitutional
Fever
Chills
Weight loss
Weight gain
Night sweats
Fatigue

Eye
Eye pain
Vision disturbance
Dry eyes
Watery eyes
Itchy eyes

ENT
Ear pain
Nosebleeds
Hoarseness
Ringing in ears
Sore throat
Mouth sores
Drainage
Congestion

Respiratory
Shortness of breath
Asthma
Sleep Apnea
Productive cough
Non-productive cough
Wheezing
*Coughing up blood
*Sputum production

Cardiovascular
Chest pain or tightness
Irregular or rapid heartbeat
Palpitations
Leg swelling
Shortness of breath when flat

GI
Black or bloody stools
Abdominal pain
Nausea/vomiting
Heartburn/acid reflux
Constipation
Loss of appetite
Diarrhea
*Difficulty swallowing
*Choking of food/liquids

Urinary
Frequent night urination

Allergy/Immunology
Food allergies
Environmental allergies
Medications allergies
Hay fever
Hives
Immune disorders

Musculoskeletal
Back pain
Neck pain
Joint swelling/Stiffness/Pain

Neurological
Numbness or tingling
Headaches
Loss of balances
Forgetfulness or Confusion
Fainting
Weakness
Dizziness
Loss of Consciousness
Seizures

Integumentary
Rash
Changes in skin color
Itching
Lesions

Psych/Social
Depression
*Anxiety

Hematologic
Bleeding easily
Swollen glands
Bruising easily

Referring Provider: _____

Care Provider: _____

Additional Comments:

_____

_____

_____

Patient Signature: _____

Date: _____

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NO SHOW AND CANCELLATION POLICY

It is our best practice to prepare our Provider with ample time scheduled for treatment for each of our patients. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. The following policies will be enforced:

- If a patient arrives 10 minutes past their scheduled time, we may have to reschedule the appointment.
- Patients who cancel their appointment the day of or miss an appointment and have not called our office prior to the scheduled appointment (NO SHOW), may be subjected to a $20 late cancellation fee. This will not be covered by your insurance company and will be billed directly to you.
- Provider may discharge a patient if multiple appointments are cancelled or no showed. A warning will be provided after the second no show and you will be discharged from our office and care with Dr. Keenan after the third no show. This includes not just office visits, but pulmonary functions test (PFT) as well.
- If ordered test (labs, imaging, PFTS, etc.) are not complete prior to your scheduled appointment, your appointment will be cancelled and only reschedule once the tests are complete.

CONSENT TO SERVICES

Your signature below indicates that you have read the office policy and agree to its terms.

Signature: _____ Date: _____