Andrew P. Pitman, M.D.
David S. Prince, M.D.
Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D.
Siva Ramachandran, M.D.

Pulmonary, Critical Care and Sleep Medicine
Bryn Mawr Medical Specialists Association
Bryn Mawr Medical Arts Pavilion
825 Old Lancaster Road, Suite 420
Bryn Mawr, PA 19010
610-527-4896

Please complete the enclosed registration and medical history forms, and bring them with you on the day of your appointment.

If your insurance company **requires a referral** for your office visit, please contact your primary doctor.

If you were instructed at the time of your call to have tests performed, and/or to bring films of any kind to your initial visit, please remember that you will need to pick up and bring with you all chest x-ray and chest CT films that were done at a facility other than Main Line Health Imaging, otherwise your appointment will need to be rescheduled.

Please provide a <u>minimum of 24 hours notice</u> if your appointment needs to be rescheduled for any reason. We reserve the right to charge for missed appointments or appointments cancelled with less than 24 hours notice.

We look forward to meeting with you!

**** Please note our address located at top ****

Andrew P. Pitman, M.D. David S. Prince, M.D. Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D. Siva Ramachandran, M.D.

Pulmonary Medicine, Critical Care Medicine and Sleep Medicine
Medical Office Building North, Suite 101
830 Old Lancaster Road, Bryn Mawr, PA 19010

NAME: _____

YOUR AGE: _____ **TODAY'S DATE:** _____

REFFERING PHYSICIAN & THEIR ADDRESS:

_____

LIST ANY OTHER MEDICAL SPECIALIST YOU REGULARLY SEE

_____

LIST THE MAIN PROBLEM, SYMPTOM OR REASONS YOU ARE COMING TO SEE THE DOCTOR:

_____

_____

LIST ALL DRUG ALLERGIES AND SENSITIVITIES:

_____

_____

LIST ALL CURRENT MEDICATIONS, STRENGTH AND FREQUENCY (include inhalers)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

LIST PAST / CURRENT MEDICAL CONDITIONS:

_____ _____
_____ _____
_____ _____
_____ _____

LIST PRIOR SURGERIES: (Also list planned surgeries)

_____ _____
_____ _____

DO YOU HAVE PROBLEMS WITH A COUGH? **YES** **NO**

If yes, describe _____

ARE YOU SHORT OF BREATH? **YES** **NO**

If yes, describe _____

ARE YOU SHORT OF BREATH AT NIGHT? **YES** **NO**

If yes, when and where?_____

DO YOU EVER WHEEZE? **YES** **NO**

DID YOU EVER HAVE PNEUMONIA VACCINE OR PNEUMOVAX?

YES **NO**

When? _____

DO YOU RECEIVE ANNUAL FLU OR INFLUENZA VACCINATION?

YES **NO**

REVIEW OF SYMPTOMS:

Circle all that apply:

GENERAL
Weight loss
Weight gain
Fever
Chills
Insomnia
Daytime fatigue
Depression

SLEEP
Insomnia
Snoring
Gasping for breath at night

GASTROINTESTINAL
Nausea
Vomiting
Heartburn or reflux
Diarrhea
Constipation
Swallowing difficulty
Choking on food
Stomach pain
Blood in stool

HEAD AND NECK
Sinusitis
Nasal congestion
Seasonal Allergies
Nosebleeds
Cough
Vision difficulties
Loss of hearing
Ringing in ears
Hoarseness

RESPIRATORY
Shortness of breath
Shortness of breath when flat in bed
Coughing up blood

CARDIAC
Palpitations
Chest pain
Swelling of legs or ankles
angina

BONE and JOINTS
Joint pain
Muscle pain
Back pain

NEUROLOGIC
Numbness
Weakness
Headache
Tremor
Poor memory

SKIN
Rash
Wounds
Bruise easily

MEN
Incontinence (loss of control urine)
Impotence
Urinary difficulty
Frequent nighttime urination

WOMEN
Incontinence (loss of control of urine
Menopause
Irregular menstrual cycle

FOR OFFICE USE ONLY

SYSTEMS REVIEWED IN FULL AND NO OTHER SIGNIFICANT FINDINGS NOTED

_____ _____

ATTENDING

WHAT IS YOUR OCCUPATION? What have you done in the past?

LIST POTENTIAL WORK OR ENVIRONMENTAL EXPOSURES:

HAVE YOU EVER SMOKED? **YES** **NO**
Are you currently smoking? **YES** **NO**
How many years total have you smoked _____ How many packs per day?_____
Have you used cigars or chewing tobacco? Describe: _____
If you stopped, how many years ago did you quit? _____
Have you tried to quit smoking before? **YES** **NO**
DO YOU DRINK ALCOHOL? **YES** **NO**
If yes, circle one: every day once or twice a week rarely/several times a month
WHO LIVES WITH YOU AT HOME?

TRAVEL HISTORY: List any significant travel within or outside of the United States in the last 5 years

LIST ALL PETS AND ANIMAL EXPOSURES / SENSITIVITES;

FAMILY HISTORY: (Circle all that apply)

Lung diseases	Asthma	Cancer	Sleep apnea
Deep vein clot (DVT)	Pulmonary emboli	Cystic Fibrosis	Stroke
Heart attack	Congestive Heart Failure	Diabetes	Depression
Hypertension	Other (please list) :		

Mother's age alive: _____ **deceased/ age:** _____ **cause:** _____
Father's age alive: _____ **deceased/ age:** _____ **cause:** _____

DO YOU SNORE? **YES** **NO**
ARE YOU SLEEPY DURING THE DAY? **YES** **NO**
DO YOU HAVE INSOMNIA? **YES** **NO**
If yes, describe : _____
DO YOU HAVE LEG DISCOMFORT ASSOCIATED WITH SLEEP? **YES** **NO**
DO YOU KICK IN YOUR SLEEP? **YES** **NO**
LIST BEDTIME _____ **LIST WAKE TIME** _____
TIME TO SLEEP ONSET_____ **Number of waking episodes at night**_____
DESCRIBE CAFFEINE USE _____