LIFEBRIDGE COMMUNITY PULMONOLOGY, INC.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ____ **Date:** __________________________________
Date of Birth: ______________________________ **Referring Physician:** ___________________________________
Reason for visit: ____
Emergency Contact:____________________________________**Phone Number:**_________________________________

Date of your most recent:

Chest X-Ray: _________________________________ Where: ____
CT Scan: ____________________________________ Where: ____
Pulmonary Function Test: ______________________ Where: ____
Bloodwork: _________________________________ Where: ____
Flu Vaccine: _________________________________ Pneumococcal (Pneumonia) Vaccine: ______________________

Social History:

Smoking: Age Started _________ Age Stopped __________ Average packs per day ___________________________
Alcohol: Never ___________ Occasional _____________ Daily ____
Illegal Drugs: Never _______ Past Use _______ Current Use ________ Which Drugs _______________________
Current Employment: ____
Past Employment: ____
Any exposure to asbestos or other dust / fumes? ____
Any pets in home? ________________________________ What kind? ____
Anything new at home that could cause breathing problems (i.e., new carpet, heating system, mold)? _______________
Any hobbies which involve exposure to dust or fumes? ____
Country where you were born: ___________________________________ Year came to the USA: __________________
Travel outside of the USA in the past 10 years (if yes, where): ____

Past Surgery or Hospital Admissions:

Date	Reason	Doctor	Hospital

Current Medications (include non-prescription):

Medication	Dose	How many times per day

Please write any additional medications on the back of this page…

Medication Allergies:

Medication	Type of Reaction

Gynecologic History (females only):

Number of pregnancies_____________ Number of live children ___________ Number of miscarriages _____________

Physicians you are seeing:

Primary: ____

Other Specialists: ____

____

____

____

Family History:

Has anyone in your immediate family had any of the following health problems:

	Mother	Father	Sister	Brother	Maternal/Paternal Grand Mother/Father
High Blood Pressure					
Diabetes					
Heart Disease					
Asthma					
Emphysema					
Congestive **H**eart **F**ailure					
Chronic **O**bstructive **P**ulmonary **D**isease (COPD)					
Stroke					
Lung Cancer					
Heart Attack					
Prostate Cancer					
Breast Cancer					
Colon Cancer					
Cancer (other)					
Melanoma					
Tuberculosis					
Thyroid Disease					
Rheumatoid Disease					
Blood Clots (leg and/or lung)					
Other					

Do you have an Advanced Medical Directive (also known as a “Living Will”, “Heath Care Proxy”, or “Health Care Power of Attorney”? ______________________

If not, are you interested in learning more about having one? ____

Patient Name:____ **Date:** ____________________________________

Past Medical History:

Have you ever had or currently suffering from the following:

	No	Yes – please describe and give dates
Glaucoma		
Cataracts		
Heart Attack		
Congestive Heart Failure		
Heart Valve Disease		
Rheumatic Fever		
Hypertension		
Pacemaker		
High Cholesterol		
Pneumonia		
Asthma		
Tuberculosis (TB)		
Pleurisy		
COPD (Chronic Bronchitis, Emphysema)		
Lung Cancer		
Bronchiectasis		
Pulmonary Fibrosis		
Asbestosis		
Pulmonary Hypertension		
Sarcoidosis		
Pneumothorax		
Pulmonary Embolism		
Pleural Effusion		
Sleep Apnea		
Ulcers		
Gallstones		
Hepatitis or Jaundice		
Colitis		
Diverticulitis		
Gastroesophageal Reflux		
Colon Cancer		
Colon Polyps		
Stomach Cancer		
Kidney Stones		
Other Kidney Disease		
Convulsions (Seizures)		
Stroke or Paralysis		
Movement Disorder		

Past Medical History (cont'd):

Have you ever had or currently suffering from the following:

	No	Yes – please describe and give dates
Diabetes		
Thyroid Disease		
Thyroid Cancer		
Allergic Rhinitis		
Sinus Disease		
Enlarged Prostate		
Prostate Cancer		
Brain Cancer		
Breast Cancer		
Cervical Cancer		
Ovarian Cancer		
Skin Cancer / Melanoma		
Ever had a blood transfusion?		
Ever have psychiatric care?		
Ever take psychiatric medication?		

Review of Systems	Most of the time	Occasionally	Never
Constitutional			
Fever			
Chills			
Sweats			
Weight loss or gain			
Eyes			
Blurred vision			
Double vision			
Spots			
Ears, Nose & Sinuses			
Ringing in ears			
Dizziness			
Ear stuffiness			
Sinus congestion			
Hay fever			

Patient Name:____ **Date:** ___________________________________

Review of Systems	Most of the time	Occasionally	Never
Mouth & Throat			
Gum disease			
Wear dentures			
Trouble swallowing			
Hoarseness of voice			
Cardiovascular			
Angina			
Chest pain			
Palpitations			
Ankle swelling			
Phlebitis (blood clots)			
Difficulty lying flat night			
Waking up short of breath			
Respiratory			
Shortness of breath			
Cough			
Sputum (phlegm)			
Pain taking a breath			
Coughing up blood			
Wheezing			
Bronchitis			
Gastrointestinal			
Indigestion or Heartburn			
Abdominal cramps or pain			
Nausea or vomiting			
Diarrhea			
Blood in stools			
Rectal bleeding			
Genitourinary			
Urinary infections			
Prostate problems			
Urinating at night			
Slowing of urinary stream			
Leaking of urine			
Blood in urine			
Irregular periods			
Heavy menstrual bleeding			

Review of Systems	Most of the time	Occasionally	Never
Musculoskeletal			
Joint pains			
*** list which joints			
Joint swelling			
Joint redness or heat			
Muscle weakness			
Back problems			
Muscle pains when walking			
Neurologic			
Fainting spells			
Speech problems			
Balance problems			
Endocrine			
Excessive thirst			
Excessive urination			
Heat or cold intolerance			
Change in voice			
Change in skin			
Skin			
Skin rash			
Change in moles			
Other skin condition			
Hematologic/Lymphatic			
Bleeding tendency			
Easy bruising			
Swollen glands			
Psychiatric			
Depression			
Anxiety			
Difficulty sleeping			

Patient Name:____ **Date:** __________________________________

Sleep Complaint Checklist

1. What is your normal bedtime during weekdays?_____________ Weekends/days off/ holidays?___________________________
2. Do you take medication(s) to help you initiate or maintain sleep? YES NO
   If yes, list medication.____
3. How many times do you typically awaken during the night? ____
   For what reason(s)?____
4. Have you ever had a sleep study done? YES NO
   If yes: where?____
   What was the outcome?____

PLEASE CHECK ALL THAT APPLY TO YOU:

_____ Snoring
_____ Gasping, choking during sleep
_____ Family members/friends observing pauses in breathing during sleep
_____ Daytime sleepiness
_____ Sleepiness while driving
_____ Inappropriate napping
_____ Difficulty falling asleep
_____ Difficulty staying asleep
_____ Awakening too early
_____ Muscle weakness while laughing or angry
_____ Irritability/Depression/Anxiety
_____ Frequent Urination disrupting sleep
_____ Inability to move (paralysis) as you are falling asleep or waking up
_____ Dry mouth in the morning

_____ Unpleasant leg sensations at bedtime
_____ Irresistible urge to move legs/arms while at rest
_____ Arms/legs jerking during sleep
_____ Teeth grinding/jaw clenching during sleep
_____ Frequent nightmares
_____ Night sweats
_____ Sleep talking
_____ Sleep walking
_____ Inability to concentrate
_____ Memory problems
_____ Pain interfering with sleep
_____ Morning headaches
_____ Vivid or lifelike visions/hallucinations while going to sleep or as you are awakening
_____ Non-restorative/ non-refreshing sleep
_____ Previously diagnosed sleep disorder(s)

_____ Home use of CPAP/BiPAP
_____ Home use of oxygen therapy

_____ Difficulty tolerating CPAP/BiPAP mask/interface
_____ Difficulty tolerating CPAP/BiPAP air pressure

Epworth Sleepiness Scale

Grade your tendency to *FALL ASLEEP* during the following situations:
(scale: 0=would never sleep, 1=slight chance of sleeping, 2=moderate chance of sleeping, 3=high chance of sleeping)

	0	1	2	3
a. Sitting and reading				
b. Watching TV				
c. Sitting active in a public place(e.g. theatre or meeting)				
d. As a passenger in a car for an hour without a break				
e. Lying down to rest in the afternoon				
f. Sitting and talking to someone				
g. Sitting quietly after lunch without alcohol				
h. In a car, while stopped for a few minutes				

Total Score

LIFEBRIDGE COMMUNITY PULMONOLOGY, LLC.
PULMONARY AND SLEEP MEDICINE

Woodholme Medical Building
1838 Greene Tree Road, Suite 350
Pikesville, MD 21208
(410) 484-5686 – Phone

Phyllis L. Green Prof. Center
826 Washington Road, Suite 130
Westminster, MD 21157
(410) 876-1914 - Phone

Name ____ ☐M ☐F SS# ________________________________

Address ______________________________________ City _________________ State ________ Zip _________

Home Phone __________________________________ Cell Phone ____

Work Phone ___________________________________ Date of Birth ___________________ Age ______________

Preferred Contact #_____Home _____Work _____Cell May we leave a detailed message? _____Yes _____No

Referring Physician _______________________________________ Primary Care Physician______________________

How did you hear about us? _ ______Ouch billboard _______Berlin questionnaire ________Referring physician

PRIMARY INSURANCE (*card must be presented*)

Insurance Company Name ____

Policy # ____ Group # ________________________________

Subscriber Name ____ Subscriber Date of Birth _____________________

Subscriber Relationship to Patient ____

SECONDARY INSURANCE (*card must be presented*)

Insurance Company Name ____

Policy # ____ Group # ________________________________

Subscriber Name ____ Subscriber Date of Birth _____________________

Subscriber Relationship to Patient ____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment of my medical benefits to Lifebridge Community Pulmonology, LLC,. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that co-pays are due at the time of service. Payment for service is accepted in the form of cash, check, Visa/MC or money order.

Patient Signature ____ Date ____________________________
(signature of parent / guardian is also acceptable if applicable)

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Westminster, MD 21157

Welcome to the practice of Lifebridge Community Pulmonology, LLC. We strive to provide outstanding medical care to you, and in order to do so we have policies in place that we want our patients to understand. The following information reflects our expectations of the partnership between the practice and our patients.

Consent for Treatment/Payment:
I am giving my consent to be treated by the practice of Lifebridge Community Pulmonology, LLC. I understand that under the Health Insurance Portability & Accountability Act (HIPAA) the practice may use and disclose my protected health information for the purposes of treatment, payment and /or healthcare operations. I have the right to review the Notice of Privacy Practices. I understand that this practice has the right to change the Notice of Privacy Practices without prior notice. I understand that I have the right to request in writing how this office uses and discloses my protected health information for the purpose of treatment, payment and / healthcare options. I also understand that this practice is not required by law to grant this request, however if the office does agree, then they are bound by the agreement. I have the right to revoke this consent in writing, except to the extent that the office has already used or disclosed by protected health information.
_____ Patient Initials

Insurance Participation and Referrals:
The practice participates with most insurance plans. It is the patient's responsibility to know the coverage and rules associated with your health insurance plan. If your health plan requires referrals, you must present a referral at the time of registration. Patients will not be seen without a referral and may be required to reschedule the visit. The office will make an effort, along with the patient, to obtain the necessary referral.
_____ Patient Initials

Authorization to Release Medical Information to Family Members:
In accordance with HIPAA, we must obtain your authorization to speak with family members regarding your medical care. If you would like this office to be able to discuss your account with family members (includes, but not limited to your healthcare / medical record, appointments, bills, etc.), please specify below:
_____ NO, DO NOT RELEASE INFORMATION TO ANYONE
_____ YES, Release my information to:

Name____ Relationship______________________________

Name____ Relationship______________________________

Appointment Policy:
Due to the overwhelming demand for appointments, we request that each patient arrive at least 15 minutes prior to your scheduled appointment time for forms, testing, etc. If you are more than 10 minutes late for your appointment, you may be asked to reschedule. We attempt to contact all patients by telephone two days prior to their appointment for a courtesy reminder, however, it is the patient's responsibility to keep track of their appointments. We request that if you cannot make your scheduled appointment you contact the office immediately to avoid a "no-show". Consistent "no-shows" will signify that you are non-compliant with your healthcare and may result in additional fees or issues with obtaining medication refills and/or future appointments.
_____ Patient Initials

____
Patient Name (please print)

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FINANCIAL POLICIES

Monthly Statements & Patient Balances

Should you have a balance due on your account, we will send you a monthly statement. The statement may show any previous balance, new charges to the account, payments and/or credits applied to the account and any additional fees if applicable. All balances on accounts are **due immediately upon receipt** of your statement unless Payment Arrangements have been made with the Billing office.

Should your account become in default by 60 days, your account will be placed on hold until satisfactory payment and/or payment arrangements have been made with the Billing office. Should your account become in default by 60 days, your account may be turned over to our collection agency, in which case, your account will be assessed a $25 fee for this service. Patient that have accounts that have been turned over to our collection agency are subject not to be seen by our practice until the account is paid in full.
____Patient Initials

Co-Pays

All co-pays are due at the time of service. Should you not have your payment available, you will have the option of being billed for your co-pay with a **$10 service fee** or rescheduling your appointment.
____Patient Initials

Returned Checks

There is a **return check fee of $35** for all checks returned by the bank and this charge will be added to your account.
____Patient Initials

Insurance Cards/Referrals

Should you give us the wrong insurance information/referral, you will be held financially liable for all fees associated with your visits.

____Patient Initials

____
Patient Name (please print)

____
Patient Signature

We accept payment in the form of
Cash, Check, Money Order, Cashier's Check, Visa and MasterCard

Account_____________

LifeBridge Community Pulmonology, LLC

This information is requested from all patients to comply with CMS reporting.

Race:

_____ Asian
_____ Native Hawaiian
_____ Other Pacific Islander
_____ Black/African American
_____ American Indian/Alaska Native
_____ White/Caucasian
_____ More than one race
_____ Decline to answer

Marital Status

_____Single
_____Married
_____Divorced
_____Widowed
_____Separated

Ethnicity:

_____ Latino or Hispanic
_____ Not Hispanic or Latino
_____ Decline to answer

Primary Language:

_____ English
_____ Spanish
_____ French
_____ German
_____ Italian
_____ Russian
_____ Other (specify)

Email:____

Name____

Signature ____