Integrity
Pulmonary
Specialist

Patient Registration

Today's Date _____

Patient's Name _____
(last) (first) (middle)

Address _____
(city) (state) (zip)

Date of Birth _____ Social Security # _____
(mm/dd/yyyy)

Current Gender Identity Male ■ Female ☐ Transgender ☐

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Work Phone _____

Business Address _____

Spouse's Name _____ Employer _____ Work Phone _____

Name of Primary Care Provider (PCP) _____ Tel _____

Address _____ Fax _____

Referring Physician (if not PCP) _____ Tel _____

Address _____ Fax _____

Emergency Contact Information _____

Friend or nearest relative not living with you _____ Phone _____

Address _____ Relationship to you _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Address _____ Tel _____

Name of Employer _____ Work Phone _____

Primary Insurance Company _____ ID# _____ Group # _____

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Patient Registration

Social History

Married ☐ Single ☐ (Year_____) Widowed ☐ (Year_____)

Present Marriage # of Years_____ Previous Marriage # of Years _____

**If not previously indicated pease complete*

*Present occupation _____ *Previous Occupations _____

*Education _____ *Spouse's Occupation _____

Persons currently living in your home _____

Do you have a living will/Advanced Directive/Polst? No ☐ Yes ☐ (please provide a copy)

Smoking? No ☐ Yes ☐ How many packs each day? _____ For how many years? _____

Alcohol? No ☐ Yes ☐ What type?_____ How many drinks per week?_____

Marijuana? No ☐ Yes ☐ Vaping? No ☐ Yes ☐ Have you ever used illegal intravenous drugs? No ☐ Yes ☐

Have you ever been tested for the HIV/AIDS virus? No ☐ Yes ☐ If yes, what was the result?_____

Have you ever been tested for Hepatitis? No ☐ Yes ☐ If yes, what was the result?_____

Self-Reporting History & Physical

Reason for this visit (chief complaint) : _____

_____

_____

Onset of illness Date_____ Symptom _____

Do you have any known genetic/predisposition to disease? No ☐ Yes ☐ Explain: _____

_____

_____

Medical History Illness/injury Date _____

_____

_____

Surgeries/hospitalizations Date _____

_____

_____

Implants: Yes ☐ No ☐ Explain _____

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Have you ever received Hormone Therapy or Chemotherapy? No ☐ Yes ☐

Medical Oncologist _____

Address _____

Medication _____ Date _____

Have you ever received Radiation Therapy? No ☐ Yes ☐

Radiation Oncologist Name _____

Address _____

What area received radiation therapy? _____

Female

Are you now, or is there a possibility that you might be pregnant? No ☐ Yes ☐ Initials ___ Date _____

Number of pregnancies _____ Deliveries _____ Did you Breastfeed? No ☐ Yes ☐

Have you ever taken Hormones? (Estrogens, Birth Control pills, Androgens, etc.) No ☐ Yes ☐

If yes, what type and for how long? _____

Do you still have menstrual periods? No ☐ Yes ☐ Date of last period _____

Allergies: (Medications, food, dust pollen, etc.)

When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes, wheezing, or rash? No ☐ Yes ☐

Explain _____

Do you have spina bifida or repeated catheterizations from congenital defects? No ☐ Yes ☐

Explain _____

Do you have breathing reactions (wheezing, shortness of breath) to tropical or pited fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)? No ☐ Yes ☐

Explain _____

Current Medications (include non-prescription)

Name of Medication	Strength of Dose (mg)	How Taken	How Often	Time of Last Dose	Reason for Use

**If more space needed please attach list of medication to this page*

Review of Symptoms

General
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Dry mouth/dehydration
- ☐ Fatigue
- ☐ Chills

Skin
- ☐ Redness/rash
- ☐ Swelling
- ☐ Moles
- ☐ Bruising
- ☐ Hair Loss
- ☐ Nail changes

Eyes
- ☐ Vision changes
- ☐ Cataracts
- ☐ Redness
- ☐ Swelling
- ☐ Pain

Ears
- ☐ Discharge
- ☐ Hearing Loss

Nose
- ☐ Discharge
- ☐ Bleeding

Throat
- ☐ Swelling
- ☐ Pain
- ☐ Mouth sores

Immunologic
- ☐ Swollen glands
- ☐ Infections
- ☐ Fevers
- ☐ Autoimmune disease(lupus, rheumatoid arthritis)

Breast
- ☐ Lumps
- ☐ Discharge
- ☐ Bleeding
- ☐ Pain

Lungs
- ☐ Cough
- ☐ Blood in sputum
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Tuberculosis

Heart
- ☐ Chest pain
- ☐ Heart palpitation
- ☐ High blood pressure

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal/stomach pain
- ☐ Black/bloody stool

Urinary
- ☐ Kidney problems
- ☐ Bladder problems
- ☐ Blood in urine
- ☐ Burning urination
- ☐ Frequent urination

Genital
- ☐ Prostate problems
- ☐ Scrotal pain
- ☐ Scrotal mass
- ☐ Ovary problems
- ☐ Uterus problems
- ☐ Vaginal discharge
- ☐ Vaginal Pain

Hormonal
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ High cholesterol

Blood
- ☐ Anemia
- ☐ Low blood counts
- ☐ Blood clots

Neurologic
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness/fainting spells
- ☐ Headaches
- ☐ Seizures
- ☐ Multiple sclerosis

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Mania

Family History

Relation	Age	State of Health	Cancer Diagnosis	Deceased Cause of Death	Age of Death	Known Genetic Abnormality
Father						
Mother						
Siblings						
Children						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Other Relatives						

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Please list all of your present physicians:

	Referring Physician seen for current problem	Other Physician seen for current problem	Other Physician seen for current problem
Name			
Address			
Telephone			
Reports	☐ Please send reports to this physician ☐ Do Not send reports	☐ Please send reports to this physician ☐ Do Not send reports	☐ Please send reports to this physician ☐ Do Not send reports

Should we contact someone to obtain your records?

	Physician/Hospital/ Other Facility	Physician/Hospital/ Other Facility	Physician/Hospital/ Other Facility
Name			
Address			
Telephone			
Study (CT, MRI, Biopsy, etc)			

Patient Signature _____ Date _____

If completed by someone other than patient:

Name _____ Relationship _____