Cheyenne Regional Medical Group
Medical Specialty Clinic

Pulmonology

2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Patient Name ____________________________________**Date:** ___________________

Provider you will be seeing: ____

PLEASE ARRIVE AT ____________________**FOR YOUR CHECK IN TIME**

Appointment Date: ____

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up **AT YOUR CHECK IN TIME** for your appointment, so our front office staff will be able to check you in in a timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.
4. **Pulmonary Patients: If the New Patient Paperwork is NOT completed at the time of visit your appointment will be CANCELLED and RESCHEDULED.**

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

Medical Specialty Clinic: Pulmonology

Patient History Questionnaire

Patient Name: ______________________________________ **Date of Birth:** _______________________
Doctor who sent you: ____
List of all the doctors you see: ____
Reason for your visit: ____

History of Present Illness

Location: _____________________________
(Where on the body symptoms occur)

Duration: ____
(How long have you had symptoms/pain? How long does it last?)

Severity: ______________________________
(Severe, worse, slightly, symptom/pain scale 1- 10)

Quality: ____
(Character of symptom/pain, burning, gnawing, stabbing)

Timing: ______________________________
(When symptoms occur? After meals or exercise, etc.?)

Context: ____
(Situation associated with symptom?)

Modifying Factors: ___________________________
(Things that make symptoms better or worse)

Associated Signs/Symptoms: ____________________________
(Other things that happen when this symptom occurs)

Past History **Please circle YES or NO if you have any of the following medical problems:**

High Blood Pressure: YES NO
Diabetes: YES NO
Heart Trouble: YES NO
Respiratory Problems: YES NO
Stroke: YES NO
Cancer: YES NO
Sleep Problems: YES NO
Bleeding Problems: YES NO
HIV/AIDS: YES NO
Other Problems: ____
____

MEDICATION ALLERGIES: ____

Current Medication	Dosage	Frequency

Past Hospitalizations / Surgeries / Injuries and Approximate Dates: _____________________________
____

Family History: Please List any Medical Problems with Your Relatives

Father: _________________________ Mother: ________________________Siblings: __________________________

Other: ____

Social History:

Do You Use Tobacco?

Never

Yes (Cigarette Packs Per Day: _____ Cigars per Day: ____ Daily Chewing Tobacco: ___)

Former (Quit Date: ______ Cigarette Packs per Day: _____ Cigars per Day: ____ Daily Chewing Tobacco: ___)

Exposed to Secondhand Smoke: YES NO

Alcohol Use: Never Rarely Moderate Daily How much? ___________________________________

Drug Use: Never Type and Frequency? ____

Occupation: ____

ADVANCED DIRECTIVES: Please Circle YES or NO

Do you have a living will: YES NO

Do you have advanced directives: YES NO

Do you have designated Durable Power of Attorney for health care: YES NO

If yes, name of durable power of attorney____

Review of Symptoms: Please Circle YES or NO if you have any of following problems:

Constitutional

Good General Health: YES NO

Recent Weight Changes: YES NO

Night Sweats / Fever: YES NO

Fatigue: YES NO

Eyes

Wear Glasses: YES NO

Blurred/Double Vision: YES NO

Eye disease or injuries: YES NO

Glaucoma: YES NO

Respiratory

Shortness of breath: YES NO

Cough: YES NO

Wheezing/Asthma: YES NO

Do You Know Your Baseline Peak Flow? __________

Coughing up blood: YES NO

History of Respiratory Infection: YES NO

Use Oxygen: YES NO

If yes: How Many Liters? ____Date Started: _______

Musculoskeletal

Muscle pain/cramps: YES NO

Stiffness/swelling joints: YES NO

Joint pain: YES NO

Trouble Walking: YES NO

Ear/Nose/Mouth/Throat

Hearing Loss or Ringing: YES NO

Sinus Problems: YES NO

Chronic Sinusitis: YES NO

Frequent Infection: YES NO

Nose Bleeds: YES NO

Sore Throat / Voice Change: YES NO

Cardiovascular

Chest Pain: YES NO

Palpitations: YES NO

Heart Trouble: YES NO

Swelling hands/feet: YES NO

Gastrointestinal

Nausea/Vomiting: YES NO

Abdominal pain: YES NO

Rectal bleeding: YES NO

Bowel problems: YES NO

Heartburn: YES NO

Neurological

Frequent Headaches: YES NO

Paralysis or tremors: YES NO

Seizures: YES NO

Numbness/tingling: YES NO

Skin/Breast

Change in hair or nails: YES NO
Rashes or itching: YES NO
Breast lump: YES NO
Breast pain or discharge: YES NO

Endocrine

Excessive thirst/urination: YES NO
Thyroid disease: YES NO
Hormone problems: YES NO

Hematologic/Lymphatic

Bruise Easily: YES NO
Slow to heal: YES NO
Enlarged glands: YES NO

Allergic/Immunologic

Food allergies: YES NO
Aspirin Allergies: YES NO
Antibiotic Allergies: YES NO
Seasonal Allergies: YES NO

Genitourinary

Blood in urine: YES NO
Kidney Stones : YES NO
Sexual Problems: YES NO
Testicle Pain: YES NO N/A
Menstrual Problems: YES NO N/A

Psychiatric

Insomnia: YES NO
Confusion/Memory loss: YES NO
Depression: YES NO
Tired/Fatigued: YES NO

Have You Experienced These Symptoms in the Past Month: **Please Circle YES or NO**

Wheezing: YES NO (If Yes, Answer the Following)

After exposures: YES NO
With exercise: YES NO
At rest: YES NO
Worse at night: YES NO

Cough: YES NO (If Yes, Answer the Following)

Production of sputum: YES NO
Dry Cough: YES NO
Coughing up Blood: YES NO
Nighttime cough: YES NO

Shortness of breath: YES NO (If Yes, Answer the Following)

At rest: YES NO
With minimal exertion: YES NO
With moderate exertion: YES NO
Climbing Stairs: YES NO
Walking <1 Block: YES NO

Other:

Chest tightness: YES NO
Inability to take full breaths: YES NO
Inability to lay flat at night: YES NO
New or worsening swelling: YES NO

EXPOSURES (TRIGGERS): Any of the Following Make Your Breathing Worse? **Please Circle YES or NO**

Cold Air: YES NO
Wind: YES NO
Respiratory infections: YES NO
Emotions/Stress: YES NO
Perfumes: YES NO
Wood Smoke: YES NO
Tobacco Smoke: YES NO
Allergies (hay fever): YES NO
Exercise: YES NO
Cleaning fluids/strong fumes: YES NO

OCCUPATIONAL HISTORY: Have you had any of the following exposures? Please Circle YES or NO

Asbestos: YES NO   Coal Mining: YES NO

Chemicals/Fumes: YES NO   Other Mining: YES NO

Explanation: ____

MILITARY HISTORY (if applicable):

What branch of the service? ____

Dates of service? ____________________________ Duties______________________________

Exposures: ____

SLEEP HISTORY: Please Circle YES or NO

Do you have a history of sleep apnea: YES NO   Any known sleep disorder: YES NO

Do you snore: YES NO   Stop breathing at night: YES NO

Have excessive leg movement: YES NO   Sleep Walk: YES NO

Do you wear a CPAP/BIPAP: YES NO

VACCINATION HISTORY: Please Circle YES or NO

Did you receive the usual childhood vaccinations: YES NO

Do you receive the yearly influenza vaccination: YES NO

Have you received a pneumonia vaccine: YES NO (If yes when? _______________)

OTHER: Please answer the following questions

Have you traveled outside the U.S. within the past six months: YES NO

History of Heartburn or Reflux Disease: YES NO

Are you currently on home oxygen: YES NO
(If Yes, Answer the Following) Date oxygen therapy started: ________ Current setting(s): __________

What times of day do you wear oxygen? Circle one:
All the time/Only at Night/Only when I feel short of breath/Only with exertion /Only when I am at rest

Do you have any pets at home: YES NO (If So What Kind _________________________)
Are you living or working on a ranch or farm: YES NO
Current hobbies: ____

____

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CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE

Dear Valued Patient,
Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all our patients.

<u>CANCELLATION OF AN APPOINTMENT</u>
In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

<u>HOW TO CANCEL YOUR APPOINTMENT</u>
To cancel an appointment, please call (307) 638-7757. If you do not reach the receptionist you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

<u>LATE CANCELLATION</u>
A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

<u>NO-SHOW PROCEDURE</u>
A "no-show" is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

- First no show: There will be no charge
- Second no show: May result in a $25 fee billed to your account
- Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.

______________________________	______________________
Patient Printed Name	Date of Birth
______________________________	______________________
Patient Signature	Today's Date

The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services!
Thank you for your support of this process.