Patient Information

Name: ____ **Nickname:** ____________________

Date of Birth: _______________ **Marital Status**: ___________________________**SS#:**_________________________
(Optional)

Address: ____
Street City State Zip

Primary phone: (_____)___________________________ **Alternate Phone**: (_____)_______________________________

Employment status: ☐full time ☐part time ☐self-employed ☐unemployed ☐student ☐retired/retirement date:________

Employer: ____ **Occupation**: ________________________________

Phone#: (_____)___________________ **May we call you at work?** ☐**Yes** ☐**No** **May we leave a message?** ☐**Yes** ☐**No**

Employer Address: ____
Street City State Zip

Due to federal requirements, please answer the following

How would you best describe your racial background? ☐White/Caucasian ☐Black/African American ☐Hispanic/Latino

☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Wish to Decline

Religious Preference: ________________ **Primary Language:** _________________

Primary Care Doctor: ______________________________ **Referring Physician**: _____________________________

Do you have an advance directive or living will? ☐yes ☐no

Name of Insurance: ______________________________________ **Are you the primary insured**? ☐**Yes** ☐**No**

If no, whom are you insured under: _________________ **Relation**: ___________________ **Date of Birth**: _________

Emergency Contact:_________________________ **Relation:**_________________ **Date of Birth**:_______________

Phone:_____________________ **Alternate phone**:____________________ **Work phone**:______________________

Address:____

____
Patient Signature **Date**

Pulmonary Care
Tel: 425-899-6972 Fax: 425-899-6970

Welcome to EvergreenHealth Pulmonary Care Center

New Patient Intake Form:

Welcome to the EvergreenHealth Pulmonary Care Center. We ask you to fill this form out to the best of your ability. Please do not leave any question unanswered. If they do not apply, feel free to write “N/A”. The thoroughness of this form will help maximize the value of your visit.

Please tell us why you are being seen in the Pulmonary Care Center_______________________________________
____
____

Other Care Providers: Please list (all) the medical providers to whom you would like us to send a copy of your records.

Name	Specialty Location
___________________________________	________________________________
___________________________________	________________________________
___________________________________	________________________________

Drug Allergies: List Any Drug Allergies and/or Adverse Drug Reactions.

Drug Name	Reaction
__________________________________	________________________________
__________________________________	________________________________
__________________________________	________________________________
__________________________________	________________________________

Medications: Please list (all) inhalers, prescription medications, over the counter medications, and any supplements included doses and frequency). Please be certain to list any medications that can thin your blood. Such as: naproxen, ibuprofen, and aspirin. Feel Free to attach a list.

Medication/Supplements

Dosage	Frequency
_________________________________	________________________________
_________________________________	________________________________
_________________________________	________________________________
_________________________________	________________________________
_________________________________	________________________________
_________________________________	________________________________
_________________________________	________________________________

Durable Medical Equipment:
Company Name: ____
Oxygen Use: Liters per minute: _________ continuous______Night time only_____
Type of portable oxygen: Tank/portable concentrator or other: ____________
CPAP or BiPAP (List setting if known) ______________
Nebulizer: **Yes** **No**
Other_________________________

Past Surgical History:	**Yes**	**No**
History of anesthesia complications?	☐	☐
History of thoracic surgery?	☐	☐

List any previous surgeries:

Procedure	**Year**
_________________________	___________
_________________________	___________
_________________________	___________
_________________________	___________
_________________________	___________

Past Medical History:	**Yes**	**No**
Heart dysfunction	☐	☐
Coronary artery disease/Stents	☐	☐
High blood pressure	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Kidney disease	☐	☐
Sleep apnea	☐	☐
Asthma	☐	☐
Seasonal Allergies	☐	☐
COPD and/or Emphysema	☐	☐
Prior admission to intensive care unit	☐	☐
Tuberculosis or positive TB skin test	☐	☐
Pneumonia, how often? ___________	☐	☐
Thyroid disease	☐	☐
Autoimmune/rheumatologic disease	☐	☐
Esophageal Reflux Disease	☐	☐

Other:

____

____

____

____

____

____

____

Family History:	**Father**	**Mother**	**Sibling**	**Child**
Heart disease	☐	☐	☐	☐
Death before 60 years	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐
Pulmonary fibrosis	☐	☐	☐	☐
Interstitial lung disease	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
COPD	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐
Other Lung Diseases	☐	☐	☐	☐

Other: ___________________________________

Social History:

Marital status *(Circle one)*: Single * Domestic partner * Widowed * Married * Divorced * Separated *

	Yes	**No**
Do you drink alcohol?	☐	☐
How many drinks a day? ______		
How many drinks a week? _____		
Have you ever used Tobacco products?	☐	☐
What type? Cigarettes/Cigar/Pipe/other		
Age started ________ Age quit ______		
Packs per day _________		
Do you use e-cigarettes/Vape/Vaporize?	☐	☐
How long? _______________		
If you're still smoking, have you ever quit?	☐	☐
Do you have a recreational drugs history?	☐	☐
What Type?______________		
Method? smoked/snorted/injected/ingested		
Do you use marijuana?	☐	☐
What form? _____________		
How often? _____________		
History of addiction?	☐	☐

Do you have any of the following?	**Yes**	**No**
Living will:	☐	☐
Durable Power of Attorney for Healthcare	☐	☐
Name: ____________________		
POLST form (Physicians orders for Life- Sustaining treatment)	☐	☐
Do you exercise?	☐	☐
What kind? ________________		
How often? ________________		

Occupational and environmental history:

List all occupations held: ________________________

____

	Yes	**No**
Exposure to inhaled fumes or dust:	☐	☐
Asbestos exposure:	☐	☐
Exposure to mold/mildew/water damage	☐	☐
Do you own or are you around birds- or down bedding/pillows?	☐	☐

What pets/animals do you own or are around?

____

Hot tubs or home water features	☐	☐

Type of home heating: _____________________

Hobbies: ________________________________

Travel History:

Where were you born? ________________________

Where have you lived? ________________________

	Yes	**No**
Traveled outside the United States-	☐	☐

What countries have you visited in the last 12 months?

____

Immunization history:

Last influenza vaccine _______________________

Last pneumonia vaccine ______________________

Last shingles vaccine ________________________

Last Tetanus/Pertussis vaccine ________________

Lungs & Heart:	**Yes**	**No**
Wheeze	☐	☐
Shortness of breath	☐	☐
Cough	☐	☐
Phlegm production	☐	☐
Cough up blood	☐	☐
Pain with breathing	☐	☐
Can you climb a flight of stairs?	☐	☐
Short of breath while lying flat	☐	☐
Passing out/lightheadedness	☐	☐
Chest pain/pressure/tightness	☐	☐
Palpitations	☐	☐
Irregular heart rate	☐	☐
Waking up short of breath	☐	☐

	Yes	No
Leg swelling	☐	☐

How far can you walk before stopping? ___________

How many pillows do you sleep on? ______________

General:	**Yes**	**No**
Fevers	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fatigue	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐

Eyes/Ears/Nose/Throat:	**Yes**	**No**
Visual changes	☐	☐
Dry Eyes	☐	☐
Sinus pressure	☐	☐
Post-nasal drip	☐	☐
Ear pain	☐	☐
Decreased hearing	☐	☐
Ear fullness	☐	☐
Sore throat	☐	☐
Hoarseness of voice	☐	☐
Tickle in throat	☐	☐
Clear throat often	☐	☐
Dry mouth	☐	☐

Other__________________

Vascular:	**Yes**	**No**
Pain in legs with walking	☐	☐
Varicose veins	☐	☐
Fingers/toes white or purple when cold (Raynaud's)	☐	☐

Gastrointestinal:	**Yes**	**No**
Heartburn	☐	☐
Sour taste in throat	☐	☐
Pain with swallowing	☐	☐
Difficulty swallowing	☐	☐
Regurgitation of food	☐	☐
Cough with eating	☐	☐
Abdominal pain	☐	☐
Jaundice	☐	☐
Change in stool color	☐	☐
Blood in stool	☐	☐
Black tar-like stool	☐	☐
Hemorrhoids	☐	☐
Ulcers	☐	☐
Belching/bloating	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

Urological:	**Yes**	**No**
Change in stream	☐	☐
Pain with urination	☐	☐
Blood in urine	☐	☐
Cloudy urine	☐	☐
Incontinence	☐	☐

Obstetrical/Gynecological:	**Yes**	**No**
Pregnancies	☐	☐
Children	☐	☐
Miscarriages	☐	☐
Heavy/painful periods	☐	☐

Other________________________________

Musculoskeletal:	**Yes**	**No**
Back pain	☐	☐
Joint pain	☐	☐

If so, specify location ____________________________

	Yes	No
Morning Joint stiffness	☐	☐
Muscle pain/soreness	☐	☐
Muscle weakness	☐	☐
Joint redness/swelling	☐	☐

Skin:	**Yes**	**No**
Rash	☐	☐
Itching	☐	☐
Dry skin	☐	☐
Psoriasis	☐	☐
Sun sensitivity	☐	☐
Hair loss	☐	☐

HEME/LYMPH:	**Yes**	**No**
Anemia	☐	☐
Easy bruising	☐	☐
Easy bleeding	☐	☐
History of transfusion	☐	☐
Enlarged lymph nodes	☐	☐
Recurrent infections	☐	☐

Sleep:	**Yes**	**No**
Snoring	☐	☐
Morning headache	☐	☐
Insomnia	☐	☐
Daytime sleepiness	☐	☐
Wake up gasping for air	☐	☐

Neurologic:	**Yes**	**No**
Headache	☐	☐
Seizure	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Impaired coordination	☐	☐
Memory problems	☐	☐

Mental health:	**Yes**	**No**
Stress	☐	☐
Depression	☐	☐
Hopelessness	☐	☐
Anxiety	☐	☐
Prior suicide attempts	☐	☐
Delusion/Hallucination	☐	☐
Manic episodes	☐	☐

Thank You,

We look forward to assisting you with all your pulmonary needs!

Patient Name: ____________________ Birth Date: ____________
Please Print

Please read the following and complete the information requested

You have the right to identify individuals other than your health care providers who are involved in your care (family, friends, or others). We may verbally share your medical information to an individual you have identified as involved in your medical care. We may also give information to someone who helps pay for your care. EvergreenHealth will only share your health information with the individuals you designate, except as required or permitted by law. You may add or change this list at any time.

Information related to Mental Health, Chemical Dependency, or HIV testing and/or therapy will only be shared with you unless specifically authorized below. (Sensitive Information)

☐ **I DO NOT authorize EvergreenHealth to verbally share information with anyone.**

I authorize EvergreenHealth to verbally share medical information/billing information with the individuals listed below:

Name	Relationship to Patient	Information to Share
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:____________
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:____________
		☐ All, including sensitive information ☐ All, not including sensitive information ☐ Specific:____________

I agree I may be contacted for appointments or follow-up information about my care at the following numbers:

Primary contact #____________ Ok to leave detailed message? ☐ Yes ☐ No

Secondary contact # ____________ OK to leave detailed message? ☐ Yes ☐ No

These designations will remain in effect indefinitely or until otherwise revoked by me in writing.

Signature: ____________________ Date: ____________
(if signed by a personal representative of the patient, please complete the following:)

Personal Representative's Name: ____________________
Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Holder of a Medical Power of Attorney*
* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

EvergreenHealth Kirkland, WA 98034

INDIVIDUALS INVOLVED IN CARE

FORM ID ADM 710
Approved 02/14

APPLY PATIENT LABEL HERE

Original - Medical Record

MR