PULMONARY CONSULTANTS
OF SOUTHWEST FLORIDA
Respiratory and Sleep Medicine
Always there for you.

REGISTRATION FORM

Patient Name:____Sex: M or F   DOB:_______________

Local Mailing Address:____

City:____State:_______________Zip:___________________

Phone-Home:____________________________________Work:_____________________________________

Mobile:_____________________________________Alternate Phone:_____________________________

Social Security __________________________Race__________Ethnicity___________________________

Single Married Divorced Widowed   Student   Language__________________________

Pharmacy______________________________Pharmacy Phone #______________________________

Pharmacy Address____

If Mailing Address is different than Physical Address, please enter information here:

Street:____

City:____State:_______________Zip:___________________

If you have an out-of-state mailing address, please enter the information here:

Street:____

City:____State:__________________Zip:___________________

Spouse/Significant Other Name:____

Emergency Contact:____Phone:__________________

<u>PATIENT WORK HISTORY</u>

Present Occupation:____Date:_________________

Prior Occupation____Date:_________________

Referred to this office by:____

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HEALTH HISTORY

Patient Name:_________________________________DOB:_______________ Today's Date: _______________

Reason for today's visit?____

Are you allergic to any medicines? ____

Do/Did you smoke cigarettes? 0 Yes 0 No If so, how old were you when you started? _______________________

What year did you quit smoking? _____________ What is/was the most you smoked daily? ______________________

Do you drink alcohol, if so list daily amount? _______________ Do you have trouble sleeping at night? 0 Yes 0 No

Nutrition/Diet: 0 Poor 0 Average 0 Good 0 Excellent 0 Vegetarian Do you exercise, if so how often:____________

What medical conditions are you currently being treated for and how long have you been treated for this condition?

1____________________________________ 4______________________________________

2____________________________________ 5______________________________________

3____________________________________ 6______________________________________

Please list any surgeries/procedures you have had and the dates?

1____________________________________ 4______________________________________

2____________________________________ 5______________________________________

3____________________________________ 6______________________________________

Family History

Mother, did she have any major medical problems? ____

If deceased, approximate age and cause: ____

Father, did he have any major medical problems? ____

If deceased, approximate age and cause: ____

# of Brothers:_____ Any major medical problems?____

# of Sisters:_______ Any major medical problems?____

How many children do YOU have? _________ Any major medical problems? ____

Do you do any recreational drugs? _______________________Do you wear your seatbelt? ___________________________