PULMONARY MEDICINE, INFECTIOUS DISEASE AND CRITICAL CARE CONSULTANTS
MEDICAL GROUP, INC.

Leaders in outcomes oriented, evidence based, compassionate, cost effective care

NEW PATIENT INFORMATION

Hello,
We are delighted that you have scheduled an appointment with Pulmonary Medicine, Infectious Disease, and Critical Care Consultants Medical Group. We are honored to participate in your health care.

PMA providers care for some of the most complicated and critically ill patients in the Greater Sacramento Area, both in area hospitals and in the outpatient office environment in three locations. PMA providers are specialists in pulmonary diseases, infectious diseases, sleep medicine, hyperbaric oxygen treatment, palliative care, and critical care medicine. PMA providers are Board Certified.

Our goal is to provide you with exceptional medical care and superior service. To help ensure you have the best possible visit, we offer a few tips:

1. Please completely fill out the Demographic and Health History Questionnaire prior to your arrival for your first appointment. We encourage you to visit our patient portal at www.pmamed.com, where some of the required documents can be printed and filled out by hand, and much of your Health History Questionnaire can easily be completed electronically. If you have completed all the requested paperwork prior to your appointment, you should plan to arrive at least 30 minutes prior to your scheduled appointment time. If you are unable to complete the required paperwork prior to your appointment, you must arrive 60 minutes prior to your scheduled time. We know that sounds like a long time, but your PMA providers want to have as much information about you as needed to provide you with exceptional medical care.

2. Please bring in all current medications or a complete list of all prescription and over-the-counter medications you are taking, along with all dose and frequency information.

3. Write down your questions or issues that you would like to cover with the doctor during your visit so you won't forget to ask and your time will be well spent.

4. Please bring your insurance card(s) and photo identification. We are required to verify the identity and insurance eligibility of all of our patients. We are also required to collect any co-payments and/or deductibles at the time services are provided.

5. Bring cash, check or credit card for your co-payment or deductible.

If you are unable to keep your appointment for any reason, please notify us at least 24 hours in advance to avoid a $50 missed appointment fee. We have set aside your appointment time just for you.

Should any questions or concerns arise before your next visit with us, please feel free to contact PMA's Central Scheduling Office by calling (916) 679-3590. We are available Monday through Friday from 8:00 a.m.-5:00 p.m.

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Date:_____

Patient

Last Name | First Name | Middle | Social Security No.

Mailing Address: Street | Apt. | City | State | Zip

Date of Birth | ☐ Male ☐ Female Sex | ☐ YES ☐ NO Pregnant | Marital Status

Home Phone | Work Phone | Cell Phone

E-mail Address | Preferred Method of Contact

Referring Doctor – Last Name, First | Primary Doctor - Last Name, First

Responsible Party

Last Name | First Name | Middle

Home Phone | Work Phone | Fax | E-mail

Mailing Address: Street | Apt. | City | State | Zip

Patient's Employer

Employer | Employer's Address | City, State, Zip

Phone and Ext | Fax | E-mail

Spouse

Last Name | First Name | Middle

Date of Birth | ☐ Male ☐ Female Sex | Social Security No.

Employer | Employer's Address | City, State, Zip

Phone and Ext | Fax | E-mail

Primary Insurance

Insurance Company Name _____ Billing Address _____ Billing Phone _____

Group Number _____ Policy or ID Number _____ Effective Date _____

Secondary Insurance

Insurance Company Name _____ Billing Address _____ Billing Phone _____

Group Number _____ Policy or ID Number _____ Effective Date _____

Emergency Contact

In addition to being my emergency contact, I authorize PMA to communicate with the individual listed below regarding any medical and/or financial issues.

Name _____ Relationship _____

Mailing Address: Street _____ Apt. _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cellular Phone _____

I hereby authorize medical treatment for the above individual by
PULMONARY MEDICINE, INFECTIOUS DISEASE AND CRITICAL CARE CONSULTANTS

SIGNATURE OF INSURED _____ DATE _____

SIGNATURE OF PATIENT OR LEGAL AGENT _____ DATE _____

THE FEDERAL GOVERNMENT REQUIRES PMA TO ASK ABOUT OUR PATIENT'S RACE AND ETHNICITY:

RACE:

- ☐ African American
- ☐ Asian
- ☐ White
- ☐ African
- ☐ Alaska Native
- ☐ American Indian
- ☐ Bahamian
- ☐ Bangladeshi
- ☐ Black or African American
- ☐ Burmese
- ☐ Cambodian
- ☐ Chinese
- ☐ Dominica Islander
- ☐ Dominican
- ☐ European
- ☐ Filipino
- ☐ Haitian
- ☐ Hmong
- ☐ Indonesian
- ☐ Iwo Jiman
- ☐ Jamaican
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Madagascar
- ☐ Malaysian
- ☐ Micronesian
- ☐ Middle Eastern
- ☐ Native Hawaiian
- ☐ Nepalese
- ☐ Okinawan
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Pakistani
- ☐ Polynesian
- ☐ Singaporian
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Tobagoan
- ☐ Trinidadian
- ☐ Vietnamese
- ☐ West Indian
- ☐ Decline to Respond

ETHNICITY:

- ☐ Central America
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic/Latino
- ☐ Latin American
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

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HEALTH QUESTIONNAIRE

We are delighted that you have scheduled an appointment with a Pulmonary Medicine Associates Medical Group provider. To help ensure that you receive the very best care and service, we would like to know more about you and your health history. Please take the time to answer all of the questions on the following pages. We look forward to seeing you at your scheduled appointment – Be sure to bring this completed form with you.

Name: _____ Birthdate:_____ Age:_____
Last First Middle

Primary Care Physician: _____ Referring Provider: _____

Additional Providers: _____

_____

Preferred Pharmacy_____ Address: _____

Preferred Lab: _____ Address: _____

Preferred Durable Medical Equipment Company: _____

Please describe your current medical problem (reason for your visit):

Current Prescription and Over-the-Counter Medications:

Medication(s) you are allergic to and <u>type of reaction</u> for each:

Vaccines
Pneumonia (Pneumovax) Date: _____

Seasonal Flu Vaccine Date: _____

YOUR PAST MEDICAL HISTORY

	Yes	No
Anemia or Blood Disorder	☐	☐
Asthma	☐	☐
Blood clot	☐	☐
Bronchitis/COPD/Emphysema	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Hay Fever or allergies	☐	☐
Heart trouble	☐	☐
High blood pressure	☐	☐
Kidney disease	☐	☐
Liver Disease	☐	☐
Musculoskeletal Disease	☐	☐
Stroke	☐	☐
Sleep Apnea	☐	☐
Tuberculosis	☐	☐
Chest X-Rays in the past 10 years	☐	☐
Year of X-Ray		
Facility/Location of X-Ray		
Hospitalizations	☐	☐
Any other chronic illness	☐	☐

YOUR FAMILY HISTORY

Relation	Cancer		Lung Disease		Heart/Vascular Disease		Rheumatoid Disease	
	Yes	No	Yes	No	Yes	No	Yes	No
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐

YOUR SURGICAL HISTORY

Procedure	Yes	No
Abdominal (belly)	☐	☐
Cancer	☐	☐
Cardiovascular (heart or blood vessels)	☐	☐
Orthopedic (bones or joints)	☐	☐
Pulmonary (lungs)	☐	☐
Other Procedure	☐	☐

SOCIAL HISTORY

	Yes	No	
Smoking Status (choose one)			
Never Smoker	☐	☐	
Former Smoker	☐	☐	Quit date?
Current Every Day Smoker	☐	☐	☐Cigarettes ☐Cigars ☐Pipe ☐Other
Current Some Day Smoker	☐	☐	How Much?
Smoker – Current Status Unknown	☐	☐	
Unknown if ever Smoked	☐	☐	
Total years of Tobacco Use			
Chewing tobacco	Yes	☐	No ☐
	☐	1/day	
	☐	2-4/day	
	☐	5+/day	

Present State of Health			
Present Job type of work			
Present Job concerns for health			
	Yes	No	
Shift work	☐	☐	
Fumes / Chemicals / Dust	☐	☐	
Radiation / X-Ray	☐	☐	
Asbestos / Known toxic materials	☐	☐	
Married	☐	☐	
Children	☐	☐	
Birthplace			
Lived in different geographic regions for over one year	☐	☐	Where?
Level of education			
List major activities and hobbies			
Household pets	Yes	No	
Dogs	☐	☐	
Cats	☐	☐	
Birds	☐	☐	
Other	☐	☐	
Deaf or have serious difficulty hearing	☐	☐	
Blind or serious difficulty seeing	☐	☐	
Difficulty concentrating, remembering, or making decisions	☐	☐	
Difficulty walking or climbing stairs	☐	☐	
Difficulty dressing or bathing	☐	☐	
Difficulty doing errands alone	☐	☐	
Do you drink coffee or caffeinated beverages?	☐	☐	If yes, how many cups per day?
Do you exercise regularly?	☐	☐	If yes, what type?
Number of alcoholic drinks per weekday day?			
Number of alcoholic drinks on weekends?			

Please indicate whether you have had any of the following conditions.

Sleep Habits	YES	NO
Daytime sleepiness	☐	☐
Snoring	☐	☐
Irregular breathing	☐	☐
Leg movements	☐	☐
Constitutional	**YES**	**NO**
Fever	☐	☐
Night sweats	☐	☐
Unintentional weight gain	☐	☐
Unintentional weight loss	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Chills	☐	☐
Any new lumps on your body ~ If yes, please indicate where:	☐	☐
Any new non healing lesion ~ If yes, please indicate where:	☐	☐
Head	**YES**	**NO**
Trauma to the head ~ if yes, when?	☐	☐
Eyes	**YES**	**NO**
Dry eyes	☐	☐
Irritation / discharge	☐	☐
Vision change	☐	☐
Ears	**YES**	**NO**
Difficulty hearing	☐	☐
Ringing in ears	☐	☐
Ear infections	☐	☐
Ear discharge	☐	☐
Ear pain	☐	☐
Vertigo (dizziness)	☐	☐
Nose	**YES**	**NO**
Frequent nosebleeds	☐	☐
Nose / sinus problems	☐	☐
Decreased sense of smell	☐	☐
Mouth / Throat	**YES**	**NO**
Sore throat	☐	☐
Gum disease	☐	☐
Dry mouth	☐	☐
Oral abnormalities	☐	☐
Mouth ulcers	☐	☐
Teeth problems	☐	☐
Dentures	☐	☐
Thrush	☐	☐
Loss of taste	☐	☐
Difficulty in swallowing	☐	☐
Pain with or when swallowing	☐	☐
Voice change	☐	☐

Cardiovascular	YES	NO
Chest pain on exertion	☐	☐
Arm pain on exertion	☐	☐
Shortness of breath when walking	☐	☐
Shortness of breath when laying down	☐	☐
Palpitations	☐	☐
Known heart murmur	☐	☐
Light-headed on standing	☐	☐
Intense pain on walking (blocked leg vessels)	☐	☐
Phlebitis (blood clot)	☐	☐
Varicose veins	☐	☐
Cold or white fingers	☐	☐
Leg edema (swelling)	☐	☐
Respiratory	**YES**	**NO**
Cough	☐	☐
Sputum production	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Pleurisy (sharp pain in chest wall when inhaling and exhaling)	☐	☐
Gastrointestinal	**YES**	**NO**
Abdominal pain	☐	☐
Vomiting	☐	☐
Change in appetite	☐	☐
Dark tarry stools or blood in the stools	☐	☐
Frequent diarrhea	☐	☐
Vomiting blood	☐	☐
Nausea	☐	☐
Constipation	☐	☐
Rectal bleeding (hemorrhoids)	☐	☐
Jaundice (yellow skin)	☐	☐
Heartburn	☐	☐
Genitourinary	**YES**	**NO**
Urinary loss of control	☐	☐
Difficulty urinating	☐	☐
Increased urinary frequency	☐	☐
Hematuria (blood in urine)	☐	☐
Incomplete bladder emptying	☐	☐
Musculoskeletal	**YES**	**NO**
Muscle aches	☐	☐
Muscle weakness	☐	☐
Arthralgias / joint pain	☐	☐
Back pain	☐	☐
Joint redness / swelling	☐	☐
Muscle wasting	☐	☐
Skin / Integumentary	**YES**	**NO**
Abnormal mole	☐	☐
Rash	☐	☐
Itching	☐	☐
Dry skin	☐	☐
Growth / lesions / skin cancer ~ if yes, where?	☐	☐
Hives		

Neurologic	YES	NO
Loss of consciousness	☐	☐
Numbness or tingling	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
Frequent / severe headaches	☐	☐
Shakiness	☐	☐
Poor balance	☐	☐
Psychiatric	**YES**	**NO**
Depression	☐	☐
Anxiety	☐	☐
Endocrinology	**YES**	**NO**
Increased thirst	☐	☐
Hair loss	☐	☐
Increased hair growth	☐	☐
Cold intolerance	☐	☐
Hematologic / Lymphatic	**YES**	**NO**
Swollen glands	☐	☐
Easy bruising	☐	☐
Gynecologic (Women)	**YES**	**NO**
Is there a chance that you are pregnant	☐	☐
Post menopausal	☐	☐
Hormone Replacement	☐	☐
Breast (Men & Women)	**YES**	**NO**
Mass (lump)	☐	☐
Nipple discharge	☐	☐
Pain or swelling	☐	☐

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Epworth Sleepiness Scale

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these activities recently, think about how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation	Chance of dozing
Sitting and reading	0 ☐ 1 ☐ 2 ☐ 3 ☐
Watching TV	0 ☐ 1 ☐ 2 ☐ 3 ☐
Sitting inactive in a public place (e.g. a theatre or a meeting)	0 ☐ 1 ☐ 2 ☐ 3 ☐
As a passenger in a car for an hour without a break	0 ☐ 1 ☐ 2 ☐ 3 ☐
Lying down to rest in the afternoon when circumstances permit	0 ☐ 1 ☐ 2 ☐ 3 ☐
Sitting and talking to someone	0 ☐ 1 ☐ 2 ☐ 3 ☐
Sitting quietly after a lunch (when you've had no alcohol)	0 ☐ 1 ☐ 2 ☐ 3 ☐
In a car, while stopped in traffic	0 ☐ 1 ☐ 2 ☐ 3 ☐
Total:	