Capitol Area Pulmonary Associates

3960 Patient Care Dr. Suite 109
Lansing, MI 48911
Phone: (517) 574-5645 Fax: (517) 574-5688

PATIENT INFORMATION

Today's Date _____

First Name _____ M.I. _____ Last Name _____ Suffix _____

Sex: ☐ Male ☐ Female Date of Birth _____ Age _____ E-mail _____

Street Address_____ Apt.____ City_____ State_____ Zip_____

Home Tel.(____) _____ Cell Phone (____) _____ Work Tel. (____) _____

Employer _____ Occupation _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Ethnicity _____

In case of emergency, please contact _____ Tel. Cell Phone (____) _____

RESPONSIBLE PARTY

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ DPOA ☐ Other: _____

First Name _____ M.I. _____ Last Name _____ Suffix _____

Sex: ☐ Male ☐ Female Date of Birth _____ Age _____ E-mail

_____

Street Address_____ Apt.____ City_____ State_____ Zip_____

Home Tel.(____) _____ Cell Phone (____) _____ Work Tel. (____) _____

SOCIAL HISTORY

Occupation _____ If retired, when? _____

Have you been exposed to any chemicals, fumes or asbestos? If yes, what? _____

Are you currently in the military or a veteran? ☐ Yes ☐ No When? _____

Do you or have you ever smoked? ☐ Yes ☐ No Packs per day? _____ How long?_____

If you quit smoking, when? _____

Does anyone in your household smoke? ☐ Yes ☐ No How long have they smoked? _____

Do you have pets in your household? ☐ Yes ☐ No If yes, what type of pet? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____ Times per week How much?_____

Do you currently or have you ever used street drugs? ☐ Yes ☐ No How often? _____ Times per week

PULMONARY ISSUES

What is your main pulmonary related problem? _____

How long have you had this problem? _____

What causes your breathing problem to worsen? _____

When did you first seek medical attention for this problem? _____

Have you seen a lung doctor in the past? ☐ Yes ☐ No If yes, who? _____ When? _____

Have you had any breathing tests in the past? ☐ Yes ☐ No If yes, when & where? _____

Have you had a chest X-Ray or CT scan of chest? ☐ Yes ☐ No If yes, when & where? _____

REVIEW OF SYSTEMS

Do you current have, or have you recently had: (Please circle the appropriate box)

Recent weight gain of 10 lbs or greater	Yes	No	Joint pain	Yes	No
Recent weight loss of 10 lbs or greater	Yes	No	Back pain	Yes	No
Fatigue	Yes	No	Joint swelling	Yes	No
Fever	Yes	No	Muscle weakness	Yes	No
Night sweats	Yes	No	Muscle pain	Yes	No
Ringing in ears	Yes	No	Dizziness	Yes	No
Loss of hearing	Yes	No	Weakness	Yes	No
Frequent sore throats	Yes	No	Numbness or tingling	Yes	No
Hoarseness	Yes	No	Memory loss	Yes	No

Sinusitis	Yes	No	Headaches	Yes	No
Shortness of breath	Yes	No	Loss of appetite	Yes	No
Chronic cough	Yes	No	Heat intolerance	Yes	No
Hemoptysis (coughing up blood)	Yes	No	Cole intolerance	Yes	No
Wheezing	Yes	No	Goiter	Yes	No
Pleurisy	Yes	No	Polydipsia (excessive thirst)	Yes	No
Chest pain	Yes	No	Heartburn	Yes	No
Palpitations	Yes	No	Abdominal pain	Yes	No
Edema (swelling in legs/feet)	Yes	No	Diarrhea	Yes	No
Syncope (passing out)	Yes	No	Blood in stool	Yes	No
Shortness of breath at night	Yes	No	Vomiting	Yes	No

HEALTH & MEDICAL HISTORY

Are you updated on your Pneumonia vaccine? ☐ Yes ☐ No When? _____

Are you updated on your Prevnar 13 vaccine? ☐ Yes ☐ No When? _____

Are you updated on your Influenza vaccine? ☐ Yes ☐ No When? _____

Are you updated on your COVID-19 vaccine? ☐ Yes ☐ No When? _____

Do you have any known allergies? ☐ Yes ☐ No Please list _____

Today's Date _____ Weight _____ lbs Height _____ft _____inches

Weight 1 year ago _____ lbs Weight 5 years ago _____ lbs

Is your body mass index (BMI) more than 35kg/m2? ☐ Yes ☐ No

Is your shirt collar 16 inches or larger? ☐ Yes ☐ No

Have you ever had lung surgery in the past? ☐ Yes ☐ No

If yes, when? _____ Where? _____

Have you ever had CABG (bypass surgery) in the past? ☐ Yes ☐ No

If yes, when? _____ Where? _____

Do you have or are being treated for high blood pressure? ☐ Yes ☐ No

Do you have a pacemaker/defibrillator with a pacemaker? ☐ Yes ☐ No

Have you ever had a Heart Valve Replacement? ☐ Yes ☐ No If yes, when? _____

Have you ever had an IVC Filter Replacement? ☐ Yes ☐ No If yes, when? _____

Have you ever had a Cholecystectomy (gallbladder removal)? ☐ Yes ☐ No If yes, when? _____

Have you ever had any type of head injury? ☐ Yes ☐ No If yes, when? _____

Have you had surgery to promote weight loss? ☐ Yes ☐ No If yes, when? _____

Do you current have, or have you ever had: (Please circle the appropriate box)

Pulmonary Hypertension	Yes	No	Hypothyroidism	Yes	No
Osteoarthritis	Yes	No	Sleep Apnea	Yes	No
Congestive Heart Failure	Yes	No	Coronary Artery Disease	Yes	No
High Blood Pressure	Yes	No	DVT (blood clots in legs)	Yes	No
Diabetes	Yes	No	Asthma	Yes	No
COPD	Yes	No	Pleural Effusion (fluid around lungs)	Yes	No
Pulmonary Embolism (blood clots in lungs)	Yes	No	Cough / Wheezing / Dyspnea	Yes	No
Emphysema	Yes	No	Pneumothorax	Yes	No
Pulmonary Fibrosis	Yes	No	Cough / Wheezing / Dyspnea	Yes	No
Lung Cancer	Yes	No	Other Cancer: _____	Yes	No

Other _____

FAMILY HISTORY

Does any member of your family have the following? (Please circle appropriate box)

COPD	Yes	No	Relationship:
Tuberculosis?	Yes	No	Relationship:

Blood Clots?	Yes	No	Relationship:
Cancer? _____	Yes	No	Relationship:
Other: _____	Yes	No	Relationship:

MEDICATIONS

Please list your medications. Attach a separate sheet if necessary.

Medication	Dose	Times /Day	Medication	Dose	Times/ Day

I verify all information provided on these forms is completely accurate to the best of my knowledge.

Patient or Responsible Party Signature _____ Date _____

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AUTHORIZED DELEGATE(S) FOR MEDICAL INFORMATION

Patient Name _____ Date of Birth _____

Please list the person(s) with whom we may discuss your medical information. If your patient is a minor, list the names of both parents.

Authorized Delegate(s) Name	Relationship to Patient

This authorization will remain in effect unless revoked by the patient or responsible party.

Patient Signature _____ Date _____

Parent or Guardian Signature (if applicable) _____ Date _____

RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

As a patient at Capitol Area Pulmonary Associates, I understand that I am here willingly and that my responsibilities as a patient include, but are not limited to, schedule and comply with all recommended follow up appointments, testing including but not limited to labs, diagnostic imaging and pulmonary function tests, any fees not covered by my insured, and discussing any concerns I have with my provider.

Patient Signature _____ Date _____

I agree to be responsible for payment of all services rendered including any deductible amount, co-insurance or any other balance not paid for by the insurance company. I understand that the insurance company may pay less than the actual bill for services and that not all services are a covered benefit. I understand that payment is due at the time of service or within 30 days of receiving a bill statement.

Patient Signature _____ Date _____

APPOINTMENT & CONTACT AGREEMENT

I understand that if I have scheduled an appointment, I must show up to the appointment. If an appointment is not canceled 24 hours in advance, I understand that I will be charged a $50 no show fee.

I, _____(print name), give permission to Capitol Area Pulmonary Associates to contact me using the telephone numbers that I have provided regarding my appointments.

Patient Signature _____ Date _____