Respiratory Specialists
2608 Keiser Blvd., Wyomissing, Pa. 19610
(610)685-LUNG (5864)
Fax: (610) 929-1528
www.lungmd.net

Date: _____

WELCOME, _____

On behalf of the Physicians and staff of Respiratory Specialists, we would like to welcome you to our practice. We specialize in the diagnosis and treatment of the lungs, sleep, and allergy disorders.

PLEASE BE SURE TO READ THIS ENTIRE LETTER AS IT CONTAINS IMPORTANT INFORMATION ABOUT YOUR FIRST VISIT TO OUR PRACTICE.

In order to best prepare you for your first visit, we would like to familiarize you with some of our office policies and procedures.

Please complete and bring in the enclosed forms to your appointment. Please do not mail these forms to the office.

- **Bring all of your health insurance cards and picture I.D. to be photocopied for your office record. Please notify your DME provider, if you have one, with the name of the specialist you are seeing so we can download your smartcard information upon arrival.**
- **If your insurance company requires an electronic or paper referral, please obtain one from your primary doctor prior to your appointment.**
  (If a referral is required and you arrive for your visit without one, you will be asked to reschedule)
- If you have had any chest X-rays and/or CT scans from any facility other than Reading Hospital or St. Joseph Medical Center please ask that facility to put them on a disc and bring that disc with you to your office visit.
- Bring in a list of **ALL** your current medications.
- **PLEASE DO NOT WEAR COLOGNE OR PERFUME TO YOUR APPOINTMENT.**

Your appointment was scheduled with Dr. _____ _____

Date: _____/_____/_____ Report to office Time: _____:_____ ___ AM ___ PM

*For appointments with Dr. Wexler, Robin Herb or allergy services; please report to the lower level in the rear of the building unless otherwise specified. *

In addition to completing the attached forms, please access our Patient Portal using the attached activation letter and complete your medical history.

Name: _____

Please note your appointment date and time below. Depending upon your contact information you gave us when scheduling your appointment you may receive reminders by e-mail 4 days prior to your appointment, cell phone text message 5 days prior to your appointment and/or a phone call 6 days prior to your appointment. You will be given an opportunity with each of those notices to either confirm or ask to be rescheduled. If for any reason you cannot keep your appointment, please notify our office at least 24 hours in advance. If you fail to provide notice there is a $30.00 charge for missed appointments that have not been cancelled with at least 24 hours notice unless otherwise determined by Administration for extenuating circumstances.

For our allergy patients, there is a $10.00 no show fee for all shots given at either location.

If you do not have your co-pay at the time of your appointment, an additional $10.00 fee will be charged.

We appreciate you choosing Respiratory Specialists for your health care needs and look forward to meeting you.
Sincerely,

Berks Schuylkill Respiratory Specialists

Respiratory Specialists

2608 Keiser Blvd. Wyomissing, Pa. 19610

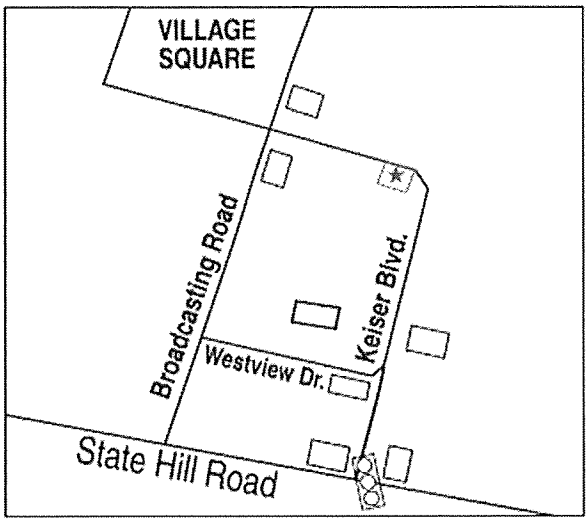
(610) 685-LUNG (5864)

WWW.LUNGMD.NET

If you need an interpreter it is YOUR responsibility to bring them to your appointment.

Revised 3/16

Name: _____



From the North:
Take 222 South. Take the Broadcasting Road Exit. Turn Right onto Broadcasting Road. Just after Spring Ridge Elementary School (on your left), turn left onto Keiser Blvd. Our driveway is the 2nd driveway on your right.

From the South:
Take 222 North. Take the Broadcasting Road Exit. Turn left onto Broadcasting Road. Just after Spring Ridge Elementary School (on your left), turn left onto Keiser Blvd. Our driveway is the 2nd driveway on your right.

From the West:
Take 422 East. Take State Hill Road Exit. Turn right onto State Hill Road. At the 7th traffic light, turn right onto Westview Drive (at traffic light, Wells Fargo Bank is on your right, Dunkin Donuts is on your left). Westview Drive turns into Keiser Boulevard around the curve in the road, then turn left into the first drive.

From the East:
Take 422 West. Follow signs for Rt. 222 North. Take the Broadcasting Road Exit. Turn left onto Broadcasting Road. Just after Spring Ridge Keiser Blvd. Our driveway is the 2nd driveway on your right.

From Rt. 183:
Take Rt. 183 South. Take the Rt. 222 Exit. Take 222 South. Take the Broadcasting Road Exit. Turn right onto Broadcasting Road. Just after Spring Ridge Elementary School (on your left), turn left onto Keiser Blvd. Our driveway is the 2nd driveway on your right.

From Rt. 61:
Take Rt. 61 South. Get on Rt. 222 South. Take the Broadcasting Road Exit. Turn right onto Broadcasting Road. Just after Spring Ridge Elementary School (on your left), turn left onto Keiser Blvd. Our driveway is the 2nd driveway on your right.

From Rt. 12 East:
Take Rt. 12 East. Take State Hill Road Exit. Turn Left onto State Hill Rd. At the 7th traffic light, turn right onto Westview Drive (at traffic light, Wells Fargo Bank is on the right, Dunkin Donuts is on your left).
Westview Drive turns into Keiser Blvd. around curve in road, then turn left to the first drive.

Name: _____

New Patient Questionnaire **Respiratory Specialists**

First Name: _____ Last Name: _____ MI: ____ Date: _____

Age: _____ Date of Birth: ____ / ____ / _____ Country of Birth:_____

Primary Care Physician: _____

What is the nature of the problem that brought you to the office:

_____

_____

Name of Emergency Contact: _____ Relationship_____
Phone number: _____

Past Medical History (check each condition that applies)

☐ Lung Disease	☐ Sleep Apnea	☐ Heart Disease	☐ High Cholesterol
☐ Asthma	☐ Insomnia	☐ Hypertension	☐ Thyroid Disease
☐ COPD	☐ Restless Leg	☐ Angioplasty/Stents	☐ Diabetes
☐ Emphysema	☐ Recurrent Sinusitis	☐ Heart Failure	☐ HIV
☐ Chronic Bronchitis	☐ Lung Cancer	☐ Stroke	☐ Hepatitis
☐Tuberculosis	☐ Other Cancer	☐ DVT/Blood Clot	☐ Lupus
☐ Sarcoidosis	☐ Allergies	☐ Pulmonary Emboli	☐ Rheumatoid Arthritis
☐ Pneumonia	☐ Fibromyalgia	☐ Kidney Disease	

Please List All Other Major Illnesses:

_____

_____

_____

Please List All Operations and Dates:

_____

_____

_____

Have you been admitted to the **Hospital** in the Last Two Years?

Date___ / ___ / ___Where_____Reason_____
Date___ / ___ / ___Where_____Reason_____
Date___ / ___ / ___Where_____Reason_____
Date___ / ___ / ___Where_____Reason_____

DME Equipment (Check appropriate answer)

☐ Oxygen ☐ Nebulizer ☐ CPAP/BiPAP

Supplier _____

Name: _____

Health History (circle appropriate answer)
Sex: ☐ **M**ale ☐**F**emale Height: _____ ft _____ in Weight: _____ lbs

Please rate your current health status: ☐ poor ☐ average ☐ good ☐ excellent

Do you currently smoke Cigarettes, Cigars, Pipe, or use Smokeless Tobacco ? ☐ Yes ☐ No
Which _____How long? (years) _____ How much per day? _____

Did you smoke Cigarettes, Cigars, Pipe or Smokeless Tobacco? ☐ Yes ☐ No Which_____

How long did you smoke? (years) _____When did you stop? _____

How much per day? _____ Why did you stop? _____

Do you have pets such as dogs, cats, or birds? ☐ Yes☐ No If "Yes" type and #_____

Please rate your current energy level: ☐ poor ☐ average ☐ good ☐ excellent

Do you snore: ☐ Yes ☐No Do you experience daytime drowsiness? ☐ Yes ☐ No

Do you feel rested in the morning? ☐ Yes ☐ No

How often do you exercise? ☐ Never ☐ occasionally ☐ regularly ☐ frequently ☐ daily

Have you gained weight over the last 5 years? ☐ Yes ☐ No If "yes" how many pounds?_____

Have you lost weight over the last 5 years? ☐ Yes ☐ No If "yes" how many pounds?_____

Alcohol Consumption: _____ # of drinks per ☐ day ☐ week ☐ month ☐ year

Occupation History:
Current:

_____
Former:

_____
If Retired: (when)

_____
If Disabled: (when/why)

_____
Any Toxin Exposure? (Asbestos, Beryllium, Lead, Coal Dust, Silica or Other) _____

Family History

Relationship	Age	Medical Problems (please list)	Deceased?
Father			
Mother			
Brother			
Brother			
Brother			

Name: _____

Sister_____
Sister_____
Sister_____
Spouse/Partner_____

MEDICATIONS

Please list all your medications below and bring bottles with you to your first appointment
*include inhalers, nebulizer solutions over-the-counter, vitamins and health supplements.

Medications	Dosage	Times per Day

ALLERGIES TO MEDICATIONS

Medication	Reaction

VACCINATIONS

Type	If YES What Year
Flu	
Pneumonia or Pneumovax	
Hepatitis	

Name: _____

REVIEW OF SYSTEMS
(Check those symptoms that YOU experience)

CONSTITUTIONAL:
☐ Change in weight
☐ Fever/chills
☐ Night sweats

RESPIRATORY:
☐ Shortness of breath
☐ Cough
☐ Coughing up blood
☐ Dust inhalation

CARDIAC:
☐ Chest pain
☐ Shortness of breath on reclining
☐ Wake up short of breath
☐ Racing/irregular heart beat
☐ Blackout spells
☐ Ankle swelling
☐ Aching legs when walking

ALLERGIC:
☐ Allergies to dust, pollen, animals
☐ Seasonal hay fever

SLEEP:
☐ Excessive sleepiness
☐ Insomnia
☐ Loud snoring
☐ Breath stop at night
☐ Leg pain at night

GASTROINTESTINAL:
☐ Nausea/vomiting
☐ Vomiting blood
☐ Difficulty swallowing
☐ Indigestion
☐ Abdominal pain
☐ Abdominal swelling
☐ Yellow jaundice
☐ Blood in stool
☐ Black tarry stool
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Hernia
☐ Hemorrhoids

GENITOURINARY:
☐ Burning on urination
☐ Nighttime urination
☐ Blood in urine
☐ Change in urine stream

EYES ,EARS, NOSE, THROAT:
☐ Difficulty hearing
☐ Ringing in ears
☐ Frequent bloody nose
☐ Hoarseness
☐ Change in vision
☐ Double vision

NEUROLOGICAL:
☐ Frequent/severe headache
☐ Numbness/tingling
☐ Uncoordination
☐ Weakness
☐ Seizures

SKIN:
☐ Itching
☐Rash
☐ Change in mole
☐ Breast pain/lump
☐ New lumps

ENDOCRINE:
☐ Heat/cold intolerance
☐ Neck irradiation
☐ Excessive thirst
☐ Unusual dietary cravings

HEMATOLOGICAL:
☐ Anemia
☐ Enlarged lymph nodes
☐ Excessive bleeding/bruising
☐ Blood clots

MUSCULOSKELETAL:
☐ Joint pain
☐ Joint stiffness
☐ Joint swelling
☐ Back pain

I have personally reviewed the past medical history, DME, health history, medications, allergies, social history, family history, and review of system during this visit.

_____

Patient Physician Clinical staff member Date

Name: _____

Part 1

In order to help diagnose and treat you, please take time to complete this questionnaire prior to your appointment. Check the block that best applies to you and bring the completed form to the office.

	Always	Freq.	Occ.	Never
I am told I snore.	☐	☐	☐	☐
I am told I stop breathing while I sleep.	☐	☐	☐	☐
I wake up choking or gasping.	☐	☐	☐	☐
I fall asleep when I don't want to.	☐	☐	☐	☐
I fall asleep when I am driving.	☐	☐	☐	☐
I have headaches in the morning	☐	☐	☐	☐
I take a nap every day.	☐	☐	☐	☐
I frequently awaken with a dry mouth.	☐	☐	☐	☐
I have difficulty concentrating.	☐	☐	☐	☐
I wish I had more energy.	☐	☐	☐	☐
I feel like I am going around in a daze.	☐	☐	☐	☐
I feel sleepy during the day even though I slept through the night.	☐	☐	☐	☐
I have trouble at work because of sleepiness.	☐	☐	☐	☐
I sweat excessively at night.	☐	☐	☐	☐
I feel my heart pounding during the night.	☐	☐	☐	☐
I have high blood pressure.	☐	☐	☐	☐
I have to get up to go to the bathroom more than once a night.	☐	☐	☐	☐
I "wet" the bed.	☐	☐	☐	☐
I drink at least three caffeinated beverages every day.	☐	☐	☐	☐
I drink caffeinated beverages every evening.	☐	☐	☐	☐
I am losing my sex drive.	☐	☐	☐	☐
I feel muscle tension in my legs other than when I am exercising.	☐	☐	☐	☐
I have noticed that part of my body jerks at night.	☐	☐	☐	☐
I have leg pain or cramps at night.	☐	☐	☐	☐
I awaken with sore muscles.	☐	☐	☐	☐
I experience vivid dream like scenes soon after falling asleep.	☐	☐	☐	☐
I have episodes of feeling unable to move after falling asleep.	☐	☐	☐	☐
I fall asleep at social settings like parties or restaurants.	☐	☐	☐	☐
My muscles go limp when I laugh, get mad, or get startled.	☐	☐	☐	☐
I find naps refreshing.	☐	☐	☐	☐
I take longer than 30 minutes to fall asleep.	☐	☐	☐	☐
I often wake up during the night and have trouble falling back to sleep.	☐	☐	☐	☐
I am sleepy before bed, but not when I go to bed.	☐	☐	☐	☐
I have thoughts racing through my head when I try to go to sleep.	☐	☐	☐	☐
I wake up for unknown reasons and I have trouble going back to sleep.	☐	☐	☐	☐
I get frustrated and/or anxious when I can't fall asleep.	☐	☐	☐	☐
I need medication or alcohol to help me sleep at night.	☐	☐	☐	☐

Part 2

Please answer the following questions:

I usually go to bed at _____

I usually wake at _____

I work day shift, evening shift, night shift. _____

Rotate shifts or not applicable _____

My neck collar size is _____

My highest weight in high school was_____

My weight 5 years ago was _____

My weight 1 year ago was _____

Name: _____

EPWORTH SLEEPINESS SCALE

Patient Name: _____ Acct: # _____ Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out 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

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

Reference: Johns, M.W. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991; 14:540-5.

Name: _____

Name: _____

Date	Any alcohol or sleeping Pills?	Any caffeine after noon?	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm	Total hours in bed?	Total time asleep?	Sleep quality (Good, fair, poor)
Example	No	None						↓	—	—	—	↑	↓	—	—	—	↑										7.5	7 hrs	good

Two Week Sleep Diary

1. Put "down" arrows at the times you went to bed and "up" arrows at the times you got out of bed.
2. Draw a line through the times you were actually sleeping.
3. Rate sleep quality as: good, fair or poor.

Name: _____

How is your COPD? Take the COPD Assessment Test™ (CAT)

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your wellbeing and daily life. Your answers, and test score, can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, place a mark checkmark in the box that best describes you currently. Be sure to only select one response for each question.

Example: I am very happy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	I am very sad
I never cough	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	I cough all the time
I have no phlegm (mucus) in my chest at all	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	My chest is completely full of phlegm (mucus)
My chest does not feel tight at all	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	My chest feels very tight
When I walk up a hill or one flight of stairs I am not breathless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	When I walk up a hill or one flight of stairs I am very breathless
I am not limited doing any activities at home	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	I am very limited doing activities at home
I am confident leaving my home despite my lung condition	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	I am not at all confident leaving my home because of my lung condition
I sleep soundly	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	I don't sleep soundly because of my lung condition
I have lots of energy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	I have no energy at all

Total Score: _____

Name: _____

Asthma Control TestTM

Your answers to this 5-question quiz will provide you a score that may help you and your doctor determine if your treatment plan is working or if it might be time for a change.
If your child is between the ages of 4 and 11 years, please use the Childhood Asthma Control Test.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?

1. **All of the time**
2. **Most of the time**
3. **Some of the time**
4. **A little of the time**
5. **None of time** **Score** _____

2. During the past 4 weeks, how often have you had shortness of breath?

1. **More than once a day**
2. **Once a day**
3. **3 to 6 times a week**
4. **Once or twice a week**
5. **Not at all** **Score**_____

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1. **4 or more nights a week**
2. **2 or 3 nights a week**
3. **Once a week**
4. **Once or twice**
5. **Not at all** **Score**_____

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

1. **3 or more times per day**
2. **1 or 2 times per day**
3. **2 or 3 times per week**
4. **Once a week or less**
5. **Not at all** **Score**_____

5. How would you rate your asthma control during the past 4 weeks?

1. **Not controlled at all**
2. **Poorly controlled**
3. **Somewhat controlled**
4. **Well controlled**
5. **Completely controlled** **Score**_____