

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 7 days prior to your appointment, cell phone text message 5 days prior to your appointment and/or a phone call 2 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 and do not keep your appointment, you will not be rescheduled without paying a \$50.00 deposit. If you show up for the rescheduled appointment, the money will be credited to your account.

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

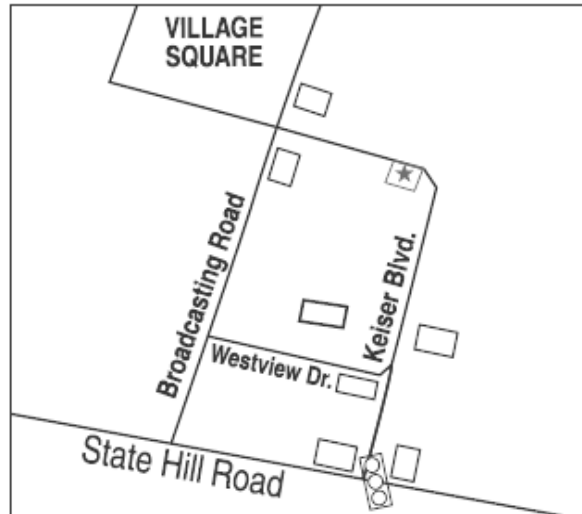
(610) 685-LUNG (5864)

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: _____

Past Medical History (check each condition that applies)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Restless Leg | <input type="checkbox"/> Angioplasty/Stents | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Recurrent Sinusitis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> DVT/Blood Clot | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Pulmonary Emboli | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> 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: Male Female 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	_____	_____	_____
---------	-------	-------	-------

Sister	_____	_____	_____
--------	-------	-------	-------

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am told I stop breathing while I sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wake up choking or gasping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fall asleep when I don't want to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fall asleep when I am driving.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have headaches in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take a nap every day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I frequently awaken with a dry mouth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish I had more energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel like I am going around in a daze.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel sleepy during the day even though I slept through the night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble at work because of sleepiness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I sweat excessively at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel my heart pounding during the night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have high blood pressure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have to get up to go to the bathroom more than once a night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I "wet" the bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I drink at least three caffeinated beverages every day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I drink caffeinated beverages every evening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am losing my sex drive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel muscle tension in my legs other than when I am exercising.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have noticed that part of my body jerks at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have leg pain or cramps at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I awaken with sore muscles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I experience vivid dream like scenes soon after falling asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have episodes of feeling unable to move after falling asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fall asleep at social settings like parties or restaurants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My muscles go limp when I laugh, get mad, or get startled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find naps refreshing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take longer than 30 minutes to fall asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often wake up during the night and have trouble falling back to sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am sleepy before bed, but not when I go to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have thoughts racing through my head when I try to go to sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wake up for unknown reasons and I have trouble going back to sleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get frustrated and/or anxious when I can't fall asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I need medication or alcohol to help me sleep at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

