Andrew P. Pitman, M.D.
David S. Prince, M.D.
Clarke U. Piatt, M.D.
Joseph M. Abboud, M.D.
Catherine A. Riley, M.D.

Pulmonary, Critical Care and Sleep Medicine
Bryn Mawr Medical Specialists Association
Bryn Mawr Medical Arts Pavilion
825 Old Lancaster Road, Suite 420
Bryn Mawr, PA 19010
610-527-4896

Please complete the enclosed registration and medical history forms, and bring them with you on the day of your appointment.

If your insurance company **requires a referral** for your office visit, please contact your primary doctor.

If you were instructed at the time of your call to have tests performed, and/or to bring films of any kind to your initial visit, please remember that you will need to pick up and bring with you all chest x-ray and chest CT films that were done at a facility other than Main Line Health Imaging, otherwise your appointment will need to be rescheduled.

Please provide a minimum of 24 hours notice if your appointment needs to be rescheduled for any reason. We reserve the right to charge for missed appointments or appointments cancelled with less than 24 hours notice.

We look forward to meeting with you!

*****Please note our address located at top*****

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NAME: _____

YOUR AGE:_____ TODAY'S DATE: _____

REFERRING PHYSICIAN NAME AND ADDRESS:

_____

LIST ANY OTHER MEDICAL SPECIALISTS YOU REGULARLY SEE:

_____

LIST THE MAIN PROBLEM, SYMPTOMS OR REASONS YOU ARE COMING TO SEE THE DOCTOR:

_____

_____

LIST ALL DRUG ALLERGIES AND SENSITIVITIES:

_____

_____

LIST ALL CURRENT MEDICATIONS, STRENGTH AND FREQUENCY (include inhalers)

_____ _____

_____ _____

_____ _____

_____ _____

LIST PAST/CURRENT MEDICAL CONDITIONS:

_____ _____

_____ _____

_____ _____

_____ _____

LIST PRIOR SURGERIES: (Also list planned surgeries)

_____ _____

_____ _____

DO YOU HAVE PROBLEMS WITH COUGH? YES NO

If yes, describe_____

ARE YOU SHORT OF BREATH: YES NO

If yes, describe_____

ARE YOU SHORT OF BREATH AT NIGHT? YES NO

If yes, describe_____

DO YOU EVER WHEEZE? YES NO

DID YOU EVER HAVE PNEUMONIA VACCINE OR PNEUMOVAX?

YES **NO**

When?_____

DO YOU RECEIVE ANNUAL FLU OR INFLUENZA VACCINATION?

YES **NO**

REVIEW OF SYMPTOMS:
Circle all that apply:

GENERAL

Weight loss
Weight gain
Fever
Chills
Night sweats
Feeling Tired (fatigue)
Other_____

SLEEP

Insomnia
Snoring
Gasping for breath at night
Involuntary movements during sleep

GASTROINTESTINAL

Nausea
Vomiting
Heartburn or reflux
Diarrhea
Constipation
Swallowing difficulty
Choking on food
Stomach pain
Blood in stool

HEAD AND NECK

Sinusitis
Nasal congestion
Seasonal Allergies
Nosebleeds
Cough
Vision difficulties
Loss of hearing
Ringing in ears
Hoarseness

RESPIRATORY

Shortness of breath
Shortness of breath when flat in bed
Coughing up blood

CARDIAC

Palpitations
Chest Pain
Swelling of legs or ankles
Angina

BONE and JOINTS

Joint pain
Muscle pain
Back pain

NEUROLOGIC

Numbness
Weakness
Headache
Tremor
Poor memory

SKIN

Rash
Wounds
Bruise easily

MEN

Incontinence (loss of control of urine)
Impotence
Urinary difficulty
Frequent nighttime urination

WOMEN

Incontinence (loss of control of urine)
Menopause
Irregular menstrual cycle

FOR OFFICE USE ONLY

SYSTEMS REVIEWED IN FULL AND NO OTHER SIGNIFICANT FINDINGS NOTED

_____ _____

ATTENDING DATE

WHAT IS YOUR OCCUPATION? What have you done in the past?

LIST POTENTIAL WORK OR ENVIRONMENTAL EXPOSURES:

HAVE YOU EVER SMOKED? YES NO
Are you currently smoking? YES NO
How many years total have you smoked? _____How many packs per day: _____
Have you used cigars or chewing tobacco? Describe: _____
If you stopped, how many years ago did you quit?_____

Have you tried to quit smoking before? YES NO

DO YOU DRINK ALCOHOL? YES NO
If yes, circle one: every day once or twice a week rarely/several times a month

WHO LIVES WITH YOU AT HOME?

TRAVEL HISTORY: List any significant travel within or outside of the United States in the last 5 years

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LIST ALL PETS AND ANIMAL EXPOSURES/SENSITIVITIES:

FAMILY HISTORY: (Circle all that apply)

Lung diseases	Asthma	Cancer		Sleep apnea
Deep vein clot (DVT)	Pulmonary emboli		Cystic Fibrosis	Stroke
Heart attack	Congestive Heart Failure		Diabetes	Depression
Hypertension	Other (please list):_____			

Mother's age alive:_____ deceased/age: _____ cause: _____
Father's age alive: _____ deceased/age: _____ cause:_____

DO YOU SNORE? YES NO

ARE YOU SLEEPY DURING THE DAY? YES NO

DO YOU HAVE INSOMNIA? YES NO

If yes, describe: _____

DO YOU HAVE LEG DISCOMFORT ASSOCIATED WITH SLEEP? YES NO

DOYOU KICK IN YOUR SLEEP? YES NO

LIST BEDTIME _____ **LIST WAKE TIME** _____

TIME TO SLEEP ONSET _____ **Number of waking episodes at night** _____

DESCRIBE CAFFEINE USE_____

NAME_____
Circle all that apply

PAST MEDICAL HISTORY

PULMONARY
Abnormal TB Test
Asthma
COPD
Cough Emphysema
Lung Mass
Pneumonia
Pulmonary Embolism
Sarcoidosis
Sleep Apnea
Tuberculosis

CARDIOVASCULAR
Atrial Fibrillation
Anemia
Coronary Artery Disease
Cardiomyopathy
Congestive Heart Failure
DVT
Hypertension
Hyperlipidemia
Peripheral Vascular Disease
Syncope
Transient Ischemic Attack

HEAD
Cataract
Glaucoma
Sinusitis
Visual Disturbances

MUSCULOSKELETAL
Connective Tissue Dx
Osteoarthritis
Osteoporosis
Systemic Lupus
Rheumatoid Arthritis

ENDOCRINE
Hypothyroidism
Hyperthyroidism
Diabetes 1
Diabetes 2

GASTROINTESTINAL
Chronic Liver Disease
Colitis
Crohn's Disease
Diverticulosis
Esophageal Reflux
Peptic Ulcer

GENITOURINARY
Benign Prostatic Hypertrophy
Erectile Disorder
Urinary Tract Infection
Renal Disorder

NEUROLOGICAL
Anxiety Disorder
Depression
Headache
Migraine Headache
Seizure Disorder

CANCER

Bladder
Bone
Brain
Breast
Cervical
Esophageal
Gastric
Hodgkin's
Laryngeal
Leukemia
Liver
Lung
Prostate
Rectal
Skin
Testicular

Non-Hodgkin's Lymphoma
Kidney
Other
Thyroid
Uterine

SURGICAL HISTORY

Thyroid Surgery
Cataract Surgery
Sinus Surgery
Thyroid Surgery
Shoulder Surgery
Wrist Surgery
Hand Surgery
Hip Surgery
Knee Surgery

HEAD & NECK
Tonsillectomy
Throat Surgery
Neck Surgery

LUNG
Bronchoscopy
Lung Biopsy
Lobectomy
Lung Surgery

GYNECOLOGICAL
Breast Biopsy
Mastectomy
C-Section
Hysterectomy

CARDIOVASCULAR
Thoracic Aneurysm
Abdominal Aortic Aneurysm
Heart Valve Replacement
PTCA-Percutaneous Transluminal Coronary Angiograph
Facial Surgery
CABG-Coronary Artery Bypass
Carotid Endarterectomy
Catheterization

GI/GU
Appendectomy
Cholecystectomy (Gallbladder)
Prostatectomy
Gastrointestinal Surgery
Bariatric Surgery