

**Andrew P. Pitman, M.D.**  
**David S. Prince, M.D.**  
**Clarke U. Piatt, M.D.**  
**Joseph M. Abboud, M.D.**  
**Siva Ramachandran, M.D.**

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Pulmonary, Critical Care and Sleep Medicine  
Bryn Mawr Medical Specialists Association  
**Medical Office Building North, Suite 101**  
**830 Old Lancaster Road**  
**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 & THEIR ADDRESS:**

\_\_\_\_\_  
**LIST ANY OTHER MEDICAL SPECIALIST YOU REGULARLY SEE**

\_\_\_\_\_  
**LIST THE MAIN PROBLEM, SYMPTOM 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 A 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, when and where? \_\_\_\_\_

\_\_\_\_\_  
**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
- Insomnia
- Daytime fatigue
- Depression

**SLEEP**

- Insomnia
- Snoring
- Gasping for breath at night

**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 urine)
- Impotence
- Urinary difficulty
- Frequent nighttime urination

**WOMEN**

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

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| <p>FOR OFFICE USE ONLY</p> <p>SYSTEMS REVIEWED IN FULL AND NO OTHER SIGNIFICANT FINDINGS NOTED</p><br><br><p style="text-align: center;">_____<br/>ATTENDING</p> |
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**WHAT IS YOUR OCCUPATION?**

What have you done in the past?

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**LIST POTENTIAL WORK OR ENVIRONMENTAL EXPOSURES:**

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**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?**

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**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;**

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**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 : \_\_\_\_\_

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**DO YOU HAVE LEG DISCOMFORT ASSOCIATED WITH SLEEP?** YES NO

**DO YOU KICK IN YOUR SLEEP?**

**YES**

**NO**

**LIST BEDTIME** \_\_\_\_\_

**LIST WAKE TIME** \_\_\_\_\_

**TIME TO SLEEP ONSET** \_\_\_\_\_

**Number of waking episodes at night** \_\_\_\_\_

**DESCRIBE CAFFEINE USE** \_\_\_\_\_