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*Pulmonary, Critical Care and Sleep Medicine
Bryn Mawr Medical Specialists Association
Bryn Mawr 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 done
and/or bring films of any kind at 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 Bryn Mawr
Hospital, 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 the 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: (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, when and where? _____

DO YOU EVER WHEEZE? YES NO

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

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) _____		

Family member with early death? If yes, describe _____

Mothers age _____ **alive / deceased cause?** _____

Fathers age _____ **alive / deceased 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** **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 _____

DID YOU EVER HAVE A PNEUMONIA VACCINE OR PNEUMOVAX? YES NO

When? _____

DO YOU RECEIVE ANNUAL FLU OR INFLUENZA VACCINATION? YES NO

REVIEW OF SYMPTOMS:

Circle all that apply:

Back pain

GENERAL

Weight loss
Weight gain
Fever
Chills
Sweats
Insomnia
Daytime fatigue
Depression

HEAD AND NECK

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

NEUROLOGIC

Numbness
Weakness
Headache
Tremor
Poor memory

SLEEP

Insomnia
Snoring
Gasping for Breath at night

RESPIRATORY

Shortness of breath
Shortness of breath when
Flat/ in bed
Coughing up blood

SKIN

Rash
Wounds
Bruise easily

GASTROINTESTINAL

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

CARDIAC

Palpitations
Chest pain
Swelling of legs or ankles
angina

MEN

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

WOMEN

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

BONE and JOINTS

Joint pain
Muscle pain

FOR OFFICE USE ONLY

SYSTEMS REVIEWED IN FULL AND NO OTHER SIGNIFICANT FINDINGS NOTED

ATTENDING