Oregon Lung Specialists, LLC

3125 Chad Dr, Suite 100
Eugene, OR 97408

Please answer every question below. The information requested will be part of your complete medical chart and will be handled in a confidential manner.

GENERAL PATIENT INFORMATION

LAST NAME | FIRST | MIDDLE

STREET ADDRESS | CITY | STATE, ZIP | EMAIL (optional)

( ) DAYTIME PHONE ☐ HOME ☐ WORK ☐ OTHER | CONTACT BY ☐ PHONE ☐ MAIL ☐ SECURE MESSAGE | DATE OF BIRTH | AGE

( ) EVENING PHONE ☐ HOME ☐ WORK ☐ OTHER | SOCIAL SECURITY NUMBER

EMPLOYER (NAME/COMPANY) | CITY | STATE | ( ) PHONE NUMBER

▲*The federal government has asked that all physician offices begin collecting information on our patients' race and ethnicity. We are asking for your help in completing the questions below, however you are not required to respond.*

If you decline to respond, please check here ☐

ETHNICITY

I am of Hispanic or Latino descent:

☐ Yes ☐ No

Preferred Language: _____

RACE I am (check any):

☐ White or Caucasian ☐ Black or African-American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

☐ Other (please list): _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY | GROUP OR LOCAL NUMBER

ADDRESS | SUBSCRIBERS DATE OF BIRTH | ID#

☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SUBSCRIBERS NAME | SUBSCRIBERS RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY | GROUP OR LOCAL NUMBER

ADDRESS | SUBSCRIBERS DATE OF BIRTH | ID#

☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SUBSCRIBERS NAME | SUBSCRIBERS RELATIONSHIP TO PATIENT

INSURANCE AUTHORIZATION & RELEASE OF INFORMATION

I hereby authorize and request my insurance company, including MEDICARE or TRICARE, to pay the physicians of Oregon Lung Specialists, LLC the amount due on my claim for service rendered to me or my dependents. I further agree to be personally responsible for the balance due on my account with Oregon Lung Specialists, LLC should the insurance company not pay my claim in full.

I authorize the release of medical information necessary to process my claim and request payment of benefits to the party who accepts assignment.

I hereby authorize Oregon Lung Specialists, LLC to send my medical evaluation(s) to my referring physician, primary care physician and/or insurance company(s).

Lastly, I authorize the following family member(s)/caregiver(s) to discuss my medical condition and/or billing information with physicians and staff of Oregon Lung Specialists, LLC. Please list name, relationship, and phone number in case of an emergency for any/all contacts.

If you decline to respond, please check here ☐

Name | Relationship | Phone Number

Signature _____ Date _____

(Patient or Authorized Person)

Name Date of birth Oregon Lung Specialists, LLC

MEDICAL HISTORY

Which Doctor Referred You To Our Office?: _____

Briefly, what is the main reason for seeing the doctor?

2) Please provide a complete list of past and present medical problems (use other side is necessary):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

3) Please list prior surgeries (use other side is necessary):

1.	4.
2.	5.
3.	6.

4) Please bring to clinic a <u>complete list of your current medications</u> and their dosages. Include all prescription, over-the-counter, and herbal/natural remedies. You may want to bring your current medications with you to the clinic.

5) Do you have any known ALLERGIES TO MEDICATIONS? ☐ **YES** PLEASE LIST BELOW ☐ No ☐ Don't Know

6) Have you had any recent CHEST x-rays or CT scans? ☐ Yes ☐ No: If yes, please provide the name of the facility where we can request your x-ray studies (if known). In addition, the date of the study is helpful:

7) About you:

• ☐ Married ☐ Single ☐ Widowed ☐ Divorced	• do you have a history of excessive alcohol use? ☐ Yes ☐ No
• Place of Birth	• Are you currently drinking alcoholic beverages? ☐ Yes ☐ No
• military service?: ☐ No: ☐ Yes: Branch _____	• Do you drink on a daily basis? ☐ Yes ☐ No if yes, how much _____ weekly if yes, how much _____ ☐ Yes ☐ No
• past & present occupation(s):	• any inhalation exposures (e.g. asbestos, work in a mine or quarry or sandblasting, work in a sawmill, any heavy dust, fumes, or chemical that caused respiratory symptoms)? ☐ Yes ☐ No ☐ Don't Know
• any known HIV risk factors ☐ Yes ☐ No ☐ Don't Know (e.g.: intravenous drug use, blood transfusion before March 1985 or, unprotected sex with partner of positive or of known HIV status, hemophilia, your mother infected at time of birth, immigrant from Haiti or East Africa)?	• what is the *most* you have smoked on a regular basis?: ☐ Never ☐ <1pk/day ☐ 1-2 pk/day ☐ >2 pk/day age when first began:_____ age when last used:_____ any significant 2nd hand smoke exposure?: ☐ Yes ☐ No
• any animals at home? ☐ Yes ☐ No • any birds at home? ☐ Yes ☐ No	

8) Have you been immunized for?:

Influenza?	☐ Yes ☐ No ☐ Don't Know	date of last vaccination (if known):_____
Pneumovax?	☐ Yes ☐ No ☐ Don't Know	date of last vaccination (if known):_____
Prevnar 13?	☐ Yes ☐ No ☐ Don't Know	date of last vaccination (if known):_____

Name _____ Date of birth _____

9) Have you ever had a tuberculin skin test (PPD)? ☐ Yes ☐ No ☐ Don't Know date of last PPD (if known):_____

If yes, was it considered "positive"? ☐ Yes ☐ No ☐ Don't Know if yes, how many millimeters?: _____

10) Do you have a living will & durable power of attorney? ☐ Yes ☐ No ☐ **I want more information**

11) Family History (Please note any known asthma, diabetes, premature heart disease (*onset of disease in men <45 yrs, in women <55 yrs*), blood clots, bleeding disorders, depression, lung cancer, or other pertinent medical disorders that you are aware of)

Father: _____

Mother: _____

Sibling(s): _____

Children: _____

REVIEW OF SYSTEMS

Please CIRCLE any symptoms that are significant problems. Use space at right to *briefly* explain or add additional comments. Items not circled will be assumed to be absent or not significant.

GENERAL		
weight change	fever-chills	night sweats
EYES		
loss of vision	blurred vision	eye pain
EARS, NOSE, MOUTH, THROAT		
sinus congestion	post-nasal drip	loss of hearing
CARDIOVASCULAR		
chest pain	ankle swelling	awaken very short-of-breath
RESPIRATORY		
shortness-of-breath	cough	cough-up blood
wheeze	snoring	excessive daytime sleepiness
GASTROINTESTINAL		
heartburn	swallowing problem	recent change in bowel habits
GENTOURINARY		
incontinence	urinary frequency	blood in urine
MUSCULOSKELETAL		
recent injury	joint swelling	joint pain
SKIN		
rash(s)	hair or nail changes	diffuse itching
NEUROLOGIC		
numbness	headaches	blackouts
PSYCHIATRIC		
depressed	panic attacks	insomnia
ENDOCRINE		
hot flashes	hot/cold intolerance	decreased libido
HEMATOLOGIC/LYMPHATIC		
swollen lymph nodes	excessive bleeding	easy bruising
ALLERGIC/IMMUNOLOGIC		
hayfever	hives	