North Point
Pulmonary Associates

3400-C Old Milton Parkway, Suite 425
Alpharetta, GA 30005

1505 Northside Forsyth Drive, Suite 3400
Cumming, GA 30042

Phone: 770-343-8760 Fax: 770-664-2101

Welcome to our practice!

On behalf of North Point Pulmonary Associates, we welcome and thank you for choosing our practice. It is our desire to make your visit a pleasant one and to work with you to establish a positive treatment plan.

Please expect to be with us for a minimum of two (2) hours; we may need to take x-rays, perform Pulmonary Function Testing and Spirometry to accurately diagnose and treat your condition.

Please help us provide the best medical care by bringing the following *required* items:

- **All of your medications**. If you are unable to bring the bottles, please bring a list of medications, the dosage, and the number of times taken daily, including all over-the-counter medications.
- **Medical records from referring physician**
- **Current X-Ray and CT/MRI Studies (Please bring film, report, and CD disc)**
- **Hospital or lab reports that may be pertinent to your first visit**
- ***Completed* History and Demographic forms**
- **Insurance Card**
- **Photo Identification**
- **Insurance Referral from your primary care physician**

We request all History and Demographic documents be completed prior to your appointment and ask that you arrive 30 minutes early. If documents aren't completed, we will need to reschedule your appointment.

Thank you for your assistance and we look forward to meeting you!

Dr. Daniel Callahan
Dr. Gayle Mason
Michael Rayburn, PA-C

Patient Name _____ Date of Birth _____

Past Medical History

Please list any medical conditions that you have been diagnosed with:

MEDICAL CONDITION	DATE DIAGNOSED	TREATING PHYSICIAN

Please list any Surgeries and hospitalizations you've ever had.

Surgery	Hospitalization/Reason	Date(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Family History

Please check all that apply:

	MOTHER	FATHER	SIBLING	GRANDPARENT	AUNT/UNCLE
Cancer (Indicate Type)					
Respiratory Disease					
Mental Illness					
High Blood Pressure					
Kidney Disease					
Diabetes					
Heart Disease					
Blood Clot					
Tuberculosis					
Other:					
Other:					

AGE OF DEATH:

Mother _____ Father _____ Siblings _____ Grandparents _____

Social History (please check one)

____ Single ____ Married ____ Divorced ____ Widowed ____ Domestic Partner

Have you ever had x-ray dye? YES/NO **Allergic to x-ray dye?** YES/NO

Have you ever smoked? YES/NO How many packs per day? _____

For how many years? _____ If you no longer smoke, when did you quit?_____

Do you consume alcohol? ____ Currently ____ In the past ____ Never If currently how much? _____

Do you or have you ever used recreational drugs? _____

Do you exercise?_____ **How often?** _____

Have you ever used diet pills? _____ **Medication** _____

Last time taken: _____

Patient Name _____ Date of Birth _____

Are you exposed to any pets? dogs, cats, birds, rodents or wild animals YES/NO

Describe _____

Have you ever worked in/with?

__ MINE __ BRICK PLANT __ FOUNDRY __ QUARRY __ POTTERY __ COTTON/FLAX/HEMP/MILL __ NONE

Have you ever been exposed to?

__ ASBESTOS __ BERYLLIUM __ ACIDS __ LEAD __ SOLVENTS __ COAL DUST __ GRINDING DUST __ NONE

Have you ever served in the military? YES/NO What Branch? _____

Dates of Service? _____

Have you ever lived in any of the following areas? (please circle)

ARIZONA, CALIFORNIA, OHIO VALLEY any other SOUTHERN STATES

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PATIENT HEALTH SUMMARY

Patient Name:	Patient DOB:

VACCINE INFORMATION

Date of last Flu Vaccine: Date of last Pneumonia Vaccine:

ALLERGIES:

DATE (diagnosed)	PAST MEDICAL HISTORY	DATE (surgery date)	PAST SURGICAL HISTORY	STAFF INITIALS

INITALLY COMPLETED BY:

Employee _____ Date _____

_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date
_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date
_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date
_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date

Review of Systems

Welcome, so that we may provide you with the best care possible, please assist us by completing the following form. Remember — always bring an updated list of all your medications including inhalers.

Please mark all that apply:

GENERAL ☐ NONE
___ Fevers
___ Night Sweats
___ Fatigue
___ Appetite Loss
___ Recent weight Changes

EYES ☐ NONE
___ Glaucoma
___ Cataracts
___ Macular Degeneration

EAR/NOSE/THROAT ☐ NONE
___ Nasal Congestion
___ Postnasal Drip
___ Voice Hoarseness
___ Sinus Disease
___ Seasonal Allergies

CARDIAC ☐ NONE
___ Heart Attack (MI)
___ Valvular Heart Disease
___ Heart Murmur
___ Rheumatic Fever
___ Abnormal Cholesterol
___ Congenital Heart Defect
___ Hypertension
___ Palpitations
___ Heart Rhythm Disorder
___ Pacemaker or Cardiac
___ Defibrillator (ICD)
___ Claudication/Leg Pains
___ Passing out/Syncope

RESPIRATORY ☐ NONE
___ Dry Cough
___ Cough with phlegm
___ Coughing up blood
___ Shortness of breath at rest
___ Shortness of breath with activity
___ Wheezing
___ Chest Tightness

SLEEP ☐ NONE
___ Morning Headaches
___ Excessive Daytime Sleepiness
___ Excessive Snoring
___ Restless Sleep
___ Sleep Disturbance Secondary to Breathing
___ CPAP/BiPAP use

GASTROINTESTINAL ☐ NONE
___ Heartburn/Reflux
___ Difficulty/Painful Swallowing
___ Abdominal Pain
___ Blood in Stool or Vomit
___ Nausea/Vomiting
___ Colostomy/Ileostomy
___ Hepatitis or Jaundice

GENITOURINARY ☐ NONE
___ Painful Urination
___ Frequent Urination
___ Blood in Urine
___ Incontinence/loss of bowel or bladder function
___ Frequent bladder/Kidney infections
___ Enlarged Prostate

GYNECOLOGICAL ☐ NONE
Are you presently or could you be pregnant? Y N
___ Abnormal Mammogram
___ Abnormal Pap smear
___ Hysterectomy

Present or past history of cancer:

Breast Y N
Please describe: _____

Ovarian Y N
Please describe: _____

Uterine Y N
Please describe: _____

MUSCULOSKELETAL: ☐ NONE
Last DEXA: _____
___ Osteoarthritis
___ Osteopenia/Osteoperosis
___ Rheumatoid Arthritis
___ Fibromyalgia
___ Gout
___ Disc Problems
___ Back Pain
___ Trouble Walking
___ Frequent Falls
___ Pain in Legs with Walking
___ Joint Pain (other than arthritis)
___ Bone Pain

NEUROLOGICAL ☐ NONE
___ Fainting Spells
___ Balance Problems
___ Tremors
___ Dizziness
___ Seizures
___ Mini strokes/TIA
___ Stroke
___ Headaches/Migraines
___ Muscle Weakness
___ Memory Problems
___ Difficulty Swallowing
___ History of Polio

BLOOD DISORDERS ☐ NONE
___ Anemia
___ Impaired Immune System
___ Low Platelets
___ Unusual Bleeding
___ Blood Clots (in legs or lungs)

ENDOCRINE ☐ NONE
___ Thyroid Problems
___ Goiter
___ Graves Disease
___ Diabetes

MENTAL/EMOTIONAL ☐ NONE
___ Excessive Stress
___ Anxiety
___ Depression
___ Suicidal Thoughts
___ Sleeping Difficulty
___ Phobias (i.e. claustrophobia)

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MEDICATIONS SUMMARY

Please list ALL current medications below: **Allergies:**

Medication	Strength	Dosage

Pharmacy Information:

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____