



North Point Pulmonary Associates

Today's Date _____

Patient Name _____

Date of Birth _____

Referring Physician _____

Primary Contact Number _____

Patient Email _____

Emergency Contact _____

Relationship & Contact Number _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

ALLERGIES TO MEDICATION? _____

SMOKING QUESTIONS

HAVE YOU EVER SMOKED OR USED TOBACCO PRODUCTS? _____ YES _____ NO

IF YES, HOW MANY PACKS PER DAY? _____ FOR HOW MANY YEARS? _____

IF YOU NO LONGER SMOKE, WHEN DID YOU QUIT? _____ HAVE YOU EVER HAD ANY KIND OF LUNG BIOPSY

OR LUNG SURGERY IN YOUR LIFE? _____ YES _____ NO IF YES, WHEN? _____

CAN WE HAVE ACCESS TO YOUR LUNG SURGICAL RECORDS? _____ YES _____ NO

VACCINATIONS

When was your last Flu shot? _____ When was your last Pneumonia Shot? _____

Have you ever had a TB skin test? _____ Have you ever tested positive for TB (Tuberculosis)? _____

When you tested positive for TB, how and where were you treated? _____

Can we have access to those TB records? _____ YES _____ NO

PHARMACY NAME _____ PHARMACY PHONE # _____

PHARMACY ADDRESS _____

DATE _____

PATIENT'S SIGNATURE