

Thomas M. Siler,
MD, FCCP, FAASM
Pulmonary Disease &
Sleep Medicine Specialist

Frank S. Calandrino, Jr.,
MD, FCCP
Pulmonary Disease &
Sleep Medicine Specialist

Sergio G. Garcia,
MD, FCCP
Pulmonary Disease &
Sleep Medicine Specialist

V. Christine Champagne,
MSN, ANP-BC, CCRC
Nurse Practitioner

Jill E. Aufmuth, MSN, ANP-BC
Nurse Practitioner

Stacey L. Brown, RN, CS, FNP, ACNP
Nurse Practitioner

Mitchell P. Champagne,
RPh, CCRC
Research Director

Susan L. Townsley,
RPSGT, RRT, RPFT
Sleep Coordinator

Experienced, comprehensive
& highly capable care for...

- Infection, disease & cancer of the lungs
- Coughing, wheezing & shortness of breath
- Fluid in the lungs & uncontrolled edema
- Chest tightness
- Coughing up blood
- Sore throat
- Snoring & sleep apnea
- Excessive daytime sleepiness & drowsy driving
- Restless leg syndrome & periodic limb movement disorder
- Insomnia
- Narcolepsy

Advanced, credentialed
& dedicated...

- Board-certified pulmonology & sleep medicine specialists
- Experienced pulmonary researchers
- Available clinical trials for eligible patients
- Advanced capabilities & technologies
- Three nurse practitioners on staff
- The region's first & only AASM-accredited sleep center
- Friendly & knowledgeable registered sleep technologists
- Individualized, compassionate care

Making it easy to get
the focused care you need...

- Lunchtime appointments available
- Insurance accepted & filed
- Visa, MasterCard & Discover cards welcome
- Free parking, including valet parking
- Handicapped-accessible

HEALTH HISTORY

Date: _____

Name: _____

Date of birth: _____ / _____ / _____
month day year

Please describe your current complaint or reason you are seeing our doctor: _____

When did problem(s) begin? _____

ALLERGIES AND/OR MEDICINE REACTIONS

Do you have allergies or reactions to any medicines/substance? Yes _____ No _____

If yes, type of reaction: (ex. rash, swelling, etc...)

Rx/Substance: _____ Reaction: _____

Rx/Substance: _____ Reaction: _____

Rx/Substance: _____ Reaction: _____

Rx/Substance: _____ Reaction: _____

SMOKING/ALCOHOL HISTORY

Have you/Do you smoke?

Never _____ Currently _____ Past/Quit _____ Date Quit: _____

Packs per day _____ Number of years _____

Other:

Pipe _____ Cigar _____ Snuff _____ Chew _____ Marijuana _____ Second-hand smoke _____

Are you interested in quitting? Yes _____ No _____

Alcohol consumption: Daily _____ Weekly _____ Monthly _____ Occasionally _____

What is your current activity level: Active _____ Sedentary _____ House Bound _____

Have you traveled outside of the US in the past 5 years? Yes _____ No _____

(If yes, where) _____

Current Occupation: _____

HOSPITALIZATION / SURGERIES (NOT LISTED ELSEWHERE) - TYPE AND DATE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Date of your most recent immunizations:

Influenza (Flu) _____ Pneumonia _____



Leaders in helping you breathe easy & sleep well.

Thomas M. Siler,
MD, FCCP, FAASM
*Pulmonary Disease &
Sleep Medicine Specialist*

Frank S. Calandrino, Jr.,
MD, FCCP
*Pulmonary Disease &
Sleep Medicine Specialist*

Sergio G. Garcia,
MD, FCCP
*Pulmonary Disease &
Sleep Medicine Specialist*

V. Christine Champagne,
MSN, ANP-BC, CCRC
Nurse Practitioner

Jill E. Aufmuth, MSN, ANP-BC
Nurse Practitioner

Stacey L. Brown, RN, CS, FNP, ACNP
Nurse Practitioner

Mitchell P. Champagne,
RPH, CCRC
Research Director

Susan L. Townsley,
RPSGT, RRT, RPFT
Sleep Coordinator

**Experienced, comprehensive
& highly capable care for...**

- Infection, disease & cancer of the lungs
- Coughing, wheezing & shortness of breath
- Fluid in the lungs & uncontrolled edema
- Chest tightness
- Coughing up blood
- Sore throat
- Snoring & sleep apnea
- Excessive daytime sleepiness & drowsy driving
- Restless leg syndrome & periodic limb movement disorder
- Insomnia
- Narcolepsy

**Advanced, credentialed
& dedicated...**

- Board-certified pulmonology & sleep medicine specialists
- Experienced pulmonary researchers
- Available clinical trials for eligible patients
- Advanced capabilities & technologies
- Three nurse practitioners on staff
- The region's first & only AASM-accredited sleep center
- Friendly & knowledgeable registered sleep technologists
- Individualized, compassionate care

**Making it easy to get
the focused care you need...**

- Lunchtime appointments available
- Insurance accepted & filed
- Visa, MasterCard & Discover cards welcome
- Free parking, including valet parking
- Handicapped-accessible

HEALTH HISTORY continued

If you have ever had a listed condition in the past, please check the Past column.

If you are presently troubled by a listed condition, please check the Present column.

If you have not experienced a problem, please check Never.

Circle or check the correct answer:

	Past	Present	Never	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productive: Yes ___ No ___ Color: _____ Blood in sputum: Yes ___ No ___
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When: Activity _____ At Rest _____ Wakes up at Night _____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With activity _____ Worse at night _____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema _____ Asthma _____ Chronic Bronchitis _____ COPD _____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack _____ CHF _____ Palpitations _____ Irregular rhythm _____
Sinus/nasal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drainage _____ Color _____ Congestion _____
High BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____ When: _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin _____ Oral medicines _____ Diet controlled _____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Congenital disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When: Any time of day _____ Morning _____ Evening _____
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring _____ Gasping for breath _____ Insomnia _____
Restless legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During the day _____ Worse at night: Yes _____ No _____
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____ When: _____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal chest xray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____ When: _____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

