PSI Pulmonary & Sleep INSTITUTE, PA

☐ New Patient NAME:_____ DATE:_____

☐ Established Patient **PRIMARY CARE PHYSCIAN:**_____

Please complete the following questions and circle only the symptoms you are having *TODAY*

Purpose of visit: ☐ FOLLOW UP ☐ NEW COMPLAINT:_____

☐ REFILL MEDICATION

REVIEW OF SYSTEMS:

GENERAL:
Fatigue
Chills
Fever
Sleep Disturbance
Weight Loss>10 Pounds
Weight Gain>10 Pounds
Sweats

CARDIOLOGY:
Chest pain
Irregular heart beat
Palpitation
Edema

RESPIRATORY:
Chest tightness
Shortness of breath: REST/EXERTION
Sputum production

ALLERGY:
Congestion
Cough
Sneezing
Watery eyes
Wheezing

GASTROINTESTINAL:
Abdominal pain
Diarrhea
Heartburn
Nausea
Vomiting

GENITO-URINARY:
Difficulty urinating
Frequency
Painful urination
Abdominal painful

ENT:
Difficulty swallowing
Dry mouth
Nosebleed
Ear pain
Sinus pain
Sore throat

MUSCULOSKELETAL:
Leg cramps
Muscle aches
Painful joints
Swollen joints
Weakness

NEUROLOGICAL:
Balance difficulty
Difficulty speaking
Dizziness
Paralysis
Tremor

PSYCHOLOGICAL:
Anxiety
Depression
Difficulty speaking
Stressors
Substance abuse

OTHER SYMPTOMS:_____
_____
_____
_____

Flu Vaccine: _____ **Pneumonia Vaccine:** _____ **COVID:** _____

DO YOU CURRENTLY USE OXYGEN? ☐ YES ☐ NO If yes, do you use oxygen during the day or night?

DO YOU CURRENTLY USE A MACHINE FOR SLEEP APNEA (CPAP, BIPAP, OR APAP)? ☐ YES ☐ NO

IF THE ANSWER IS YES, PLEASE LIST YOUR DURABLE MEDICAL EQUIPMENT (DME) COMPANY THAT PROVIDES YOUR ***OXYGEN*** OR ***SLEEP APNEA MACHINE***: _____

EMAIL FOR PATIENT PORTAL:_____