Newark Beth Israel Medical Center | RWJBarnabas HEALTH

Darrell K. Terry, Sr., MHA, MPH, FACHE
President and Chief Executive Officer

Dear Patient:

Thank you for choosing the Advanced Lung Disease & Transplant Program at Newark Beth Israel center. We look forward to meeting with you at the first visit. In order to make the visit more efficient we will be requesting the following documents which will allow our team to better understand your clinical history.

Please complete the enclosed NEW PATIENT PACKAGE and return to the office prior to your appointment. You can either fax this to us at (973)926-5658 or mail the packet to us at the address listed below if time permits.

- Registration form in its entirety
- Progress Note pages 1-6
- Provider Information Sheet
- Medical Record Release Form
- Self Enrollment for the Patient Portal

We will be requesting your records from the referring MD. Please be aware that HIPPA law requires an Authorization from the patient to obtain these records. We will be requesting the following

- Summary of history: Office progress note
- Cath, Echo, CT of chest, Chest X-ray, PFT reports, blood work, any testing pertaining to consult
- Any documentation your referring physician would like for us to review

*** Please check to determine If your insurance requires a referral, so you can obtain one prior to the visit. Unfortanetly we will not be able to complete a visit if a referral is required and has not been obtained.

Our team welcomes you to our practice. Please let us know how we can assist you through out the course of your care. We strive to meet all of your needs. If you need assistance with the paperwork or have any questions regarding your visit please contact us at (973)926-4430

Thank you,

Advanced Lung Disease & Transplant Program

201 Lyons Avenue
at Osborne Terrace
Newark, NJ 07112

973.926.7000

Newark Beth Israel Medical Center
Children's Hospital of New Jersey
Barnabas Health

BARNABAS LUNG CENTER INTAKE FORM

Name: _____ **Today's Date:** _____/ _____/ _____

Date of Birth: _____/ _____/ _____ **Ht:** _____**Wt:**_____lbs

Allergies: ☐ Latex

Type	**Reaction**

Tobacco History: **YES** **NO**

Do you have a history of tobacco use? ☐ ☐

If YES, how many years have you smoked? _____ How many cigarettes/packs per day? _____

Are you still smoking? **YES** ☐ **NO** ☐

If NO, what year did you quit? _____

How much did you smoke and for how many years? _____

PAST MEDICAL HISTORY: To be completed by patient or family member

Please take some time to think about these questions. Answer to the best of your ability. If you can't answer a question, just write "I don't know". Our staff will go over this questionnaire with you at the time of your visit. If you have had any recent cardiac testing, please have it forwarded to our office prior to your visit.

	Yes	**No**	**Unknown**	**Year Diagnosed**
1. Pneumonia	☐	☐	☐	_____
Treatment: _____				
2. Asthma	☐	☐	☐	_____
Treatment: _____				
3. Coronary Artery Disease	☐	☐	☐	_____
Treatment: _____				
4. Heart Attack	☐	☐	☐	_____
Treatment: _____				

Name: _____

PAST MEDICAL HISTORY (continued):

	Yes	No	Unknown	Year Diagnosed
5. Congestive Heart Failure (CHF)	☐	☐	☐	_____
Treatment: _____				
6. Irregular Heart Beats (palpitations)	☐	☐	☐	_____
Treatment: _____				
7. High Blood Pressure	☐	☐	☐	_____
Treatment: _____				
8. Daily Cough	☐	☐	☐	_____
If yes, amount of sputum produced: _____				
9. Diabetes	☐	☐	☐	_____
Treatment: _____				
10. Other breathing problems (snoring)	☐	☐	☐	_____
Treatment: _____				
11. Thyroid problems	☐	☐	☐	_____
Treatment: _____				
12. Stomach (GI) problems	☐	☐	☐	_____
Treatment: _____				
13. Kidney problems	☐	☐	☐	_____
Treatment: _____				
14. Bladder/prostate problems	☐	☐	☐	_____
Treatment: _____				
15. Cancer	☐	☐	☐	_____
Treatment: _____				
16. Recurrent Pain	☐	☐	☐	_____
Treatment: _____				
17. Depression/Anxiety	☐	☐	☐	_____
Treatment: _____				

Name: _____

History of blood transfusions: ☐ **No** ☐ **Yes**

If **Yes**, when? _____

Females Only: Date of Last Mammography: _____

Date of Last PAP test: _____

Risk of Pregnancy ☐ **No** ☐ **Yes**

If No Explain Why: _____

Number of total Pregnancies _____ Number of Abortion/miscarriages _____

Pain History: ☐ **No** ☐ **Yes**, if yes please describe:

_____

_____

_____

Have you ever been seen by a pain management provider? ☐ **No** ☐ **Yes** If yes please explain:_____

PAST SURGICAL HISTORY (include year and hospital):

_____

_____

_____

_____

PAST PROCEDURES (For example: lung biopsy,bronchoscopy, other):

_____

_____

_____

_____

_____

ANY RECENT DIAGNOSTIC TESTING (For example: chest xray, echocardiogram, pulmonary function tests, etc):

_____

_____

_____

_____

Name: _____

Please describe when you first had breathing problems. What happened?

_____

_____

_____

_____

When and where were you last in the hospital for your breathing problems?

_____

SYMPTOMS:

If YES, please indicate the frequency: **Occasionally (O), Frequently (F) or Continuously (C):**

	YES	NO	How Often
1. Leg swelling	☐	☐	_____
2. Fatigue	☐	☐	_____
3. Palpitations	☐	☐	_____
4. Dizziness	☐	☐	_____
5. "Passing out"	☐	☐	_____
6. Shortness of breath (at rest)	☐	☐	_____
7. Shortness of breath (on exertion)	☐	☐	_____
8. Waking at night unable to breathe	☐	☐	_____
9. Cough	☐	☐	_____
10. Wheeze	☐	☐	_____
11. Abdominal pain/bloating	☐	☐	_____
12. Nausea/vomiting	☐	☐	_____
13. Diarrhea	☐	☐	_____
14. Difficulty sleeping	☐	☐	_____
15. Muscle aches/cramps	☐	☐	_____
16. Fever/chills/sweating	☐	☐	_____
17. Headaches	☐	☐	_____
18. Gout	☐	☐	_____
19. Chest pain	☐	☐	_____
20. Other current pain	☐	☐	_____

Please describe: _____

21. How far can you walk without stopping? _____ (example: feet, yards, blocks, miles)

22. What limits how far you can walk? _____

Name_____

23. How many pillows do you sleep on? _____

24. Can you lay flat? _____

25. Do you lose or gain weight? _____

26. Do you have any diet/dietary restrictions? _____

SOCIAL HISTORY:

Alcohol History:	**YES**	**NO**
Do you have a history of alcohol use?	☐	☐
Do you still drink?	☐	☐

If **Yes**, how long have you been drinking and how much per day/week? _____

If **No,** what year did you stop drinking? _____

How much did you drink and for how long? _____

Illicit Drug History:	**YES**	**NO**
Do you have a history of illicit drug use?	☐	☐
Do you still use drugs?	☐	☐

If YES, what drug(s) do you use? _____

Number of years used _____

Personal History:

Employment: Please circle one: Unemployed Employed Retired Disabled

Occupation: _____

Last grade you finished in school: _____

Martial status: Please circle one: Single Married Divorced Widowed

Number of children: _____ Who do you live with? _____

Do you have a history of high risk sexual activity?: _____

FAMILY HISTORY: (please tell us your family's present or past health problems)

Mother: Father:

_____ _____

_____ _____

Brothers/Sisters Close family members with health problems:

_____ _____

_____ _____

_____ _____

Children

_____ _____

_____ _____

Name: _____

MEDICATIONS:

Pharmacy Name: _____ Location:_____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Medication Name	Dose	Frequency

Form completed by: _____ _____

Name Signature

Relationship to Patient: ☐ Self ☐ Spouse Other: _____

Date: _____

I have read and verified patient's health history, answers to questions and medication list.

Signature/Title_____ Date: _____