Dallas Diagnostic Association – Pulmonary & Critical Care
Dr Mari Adachi M.D. Dr Omar Awad M.D., F.C.C.P.
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Plano, TX 75093
(469) 800-6036

New Patient Form

Date: _____

Patient Name: _____ **D.O.B:** _____

Primary/Referring Physician(s): _____

Address(s): _____

Physician(s) Telephone Number(s): _____

Primary reason for Pulmonology (Lung) Referral/Brief description of problems: _____

_____

Past History (Check all that apply)

☐ Asthma	☐ Emphysema	☐ Pneumonia	☐ Cancer
☐ Tuberculosis	☐ Diabetes	☐ Stroke	☐ High Blood Pressure
☐ Seizures	☐ Thyroid Problems	☐ Liver Problems	☐ Ulcers
☐ Kidney Problems	☐ Heart Attack	☐ Heart Problems	☐ Arthritis
☐ Bleeding Problems	☐ COPD Chronic	☐ Bronchitis	☐ Pleural Effusion
☐ Hypertension			

Please list all past surgery(s): _____

_____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

When did you quit? _____

Have you ever tried Cocaine, Heroin, Amphetamine, Marijuana, or any other illicit drugs?

Occupation: _____ Marital status: _____

Children: _____ Pets: _____

Any recent travel(s)? _____

Family History

Relationship	Age (if living)	Age at death	State of health/Cause of death
Mother:			
Father:			
Sister(s):			
Brother(s):			
Children:			

List all medications you are presently taking including inhalers, nebulizer medications, and any over the counter medications you are taking on a regular basis:

Name	Dose	Quantity per day	How long on this medication?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you allergic to any medications? _____

_____

Are you currently on oxygen? ☐ **Yes** ☐ **No**

Are you on a BIPAP machine? ☐ **Yes** ☐ **No**

Are you on a CPAP machine? ☐ **Yes** ☐ **No**

Have you ever taken steroid medication? ☐ **Yes** ☐ **No**

What was the longest period of steroid treatment w/o interruptions? _____

What was the usual dosage or dose range? _____

Did you experience any side effects from the steroids? ☐ **Yes** ☐ **No**

If so, please describe: _____

_____

Patient Signature: _____

Physician Signature: _____

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