Patient Information Sheet

Name (*legal name*): ____

Date of Birth: ______________ Social Security Number: ______________________

Male ______ Female ______ Height _________ Weight __________ Was This an Injury _______

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________

Emergency Contact: ______________________________ Phone: ______________
(Someone not living with you)

Address: ____

Primary Insurance: ____

Address: ______________________________ Phone: ______________________

Name as on Card: ____

ID: ______________________________ Group: ______________________

Insured: Self ____ Spouse _____ Parent ____ Name: ______________________________

Insured SS Number: ______________________ Insured Date of Birth: ______________

Secondary Insurance: ____

Address: ______________________________ Phone: ______________________

Name as on Card: ____

ID: ______________________________ Group: ______________________

Insured: Self ____ Spouse _____ Parent ____ Name: ______________________________

Insured SS Number: ______________________ Insured Date of Birth: ______________

Physician's Name: ______________________________ Phone: ______________________

Address: ____

Medical equipment needed: ____

Medical Condition Related to Equipment Needed: ______________________________

Have you ever had the equipment needed before? Yes _____ No _____

If yes, how long ago and reasoning for another: ______________________________

Last time you have seen your physician: ______________________________

List any medical equipment currently using: ______________________________

Are you on Home Health? Yes ____ No _____; what company? ______________________

Patient Information Sheet

Respiratory Screen

Do you have any of the following?

Shortness of breath at rest ______

Wheezing _______

Shortness of breath during activities ______

Cough (for 3 months or longer) ______

Daytime Sleepiness ______

Cough with sputum ______ without sputum ______

Snoring ______

Ankle Swelling ______

Dizziness ______

Asthma ______

History of Stroke/CVA _______

Have you discussed any of the above with your physician? Yes ______ No _______

If yes, what physician and when ____

Have you ever been diagnosed with?

COPD ________ CHF ________

Currently using nebulizer? Yes _____ No ______

If yes, what type of medication ____

Currently using inhaler? Yes ______ No ______

If yes, what type ____

Currently on oxygen? Yes _____ No _____

If yes, what company are you currently using ____

Have you ever been on oxygen in the hospital? Yes ______ No _______

If yes, when and where ____

____ ___________________________

Patient Signature Date