



Springfield Pulmonary Medicine & Sleep Clinic

Ramesh Chadalavada, M.D. / Michele Potter, PA-C
 221 NorthCrest Drive, Springfield, TN 37172
 Phone: 615-384-2149 Fax: 615-384-9384

Patient Name:		Pt. Sex M F	Social Security #:	Date:
Street Address:		Date of Birth:	Age:	Race/Ethnicity:
City:	State:	Zip Code:	Email:	
Cell Phone:	Home Phone:	Work Phone:	Name of Spouse if Married:	
May we leave message concerning appoints on: (Please circle) Home Work Cell Emerg. Contact None				
To whom may we release medical information about you?				
Name:		Phone Number:		
Name:		Phone Number:		
Pharmacy:	City:	Pharmacy Phone:		
Emergency Contact #1:	Relationship:	Phone Number:		
Emergency Contact #2:	Relationship:	Phone Number:		
Subscriber Name:		Relationship to patient:		
Insurance Company Name:				
Employer Name:	Employer Phone #:	Occupation:		
Advanced Directives				
Do you have a Living Will?		Yes	No	
Do you have a Durable Power of Attorney for Healthcare?		Yes	No	
Have you provided a copy of these to our office?		Yes	No	
<p>The information above is correct to the best of my knowledge. I understand that Springfield Pulmonary Medicine files insurance as a courtesy and if for any reason insurance denies payment, I am financially responsible for all charges associated with my visit.</p>				
Signature of Patient _____			Date: _____	
(Legal Guardian if Patient is a minor)				
Primary Care Physician:				



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Referring Physician:	Reason for Referral:
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Past Medical History (Please circle all that apply)

Hypertension	Diabetes	Heart Disease	Heart Attack	Arrhythmia/A Fib
Pacemaker	High Cholesterol	Stroke	Seizures	COPD/Asthma
Allergic Rhinitis	Sinusitis	Pneumonia	Gallstones	Kidney Stones
Prostate Issues	Cancer	GERD/Ulcers	Arthritis	Lupus
Depression	Anxiety	Back Problems	Hypothyroid	Hepatitis
UTI/Kidney issue	TB	Rheumatic Fever	Hyperthyroid	

Past Surgical History (Please circle all that apply)

Appendectomy	Cataracts	Glaucoma	Tonsillectomy	Adenoidectomy
Gallbladder	Prostate Surgery	Joint Surgery	Heart Surgery	Vascular Surgery
Hysterectomy	Tubal Ligation	Lung Surgery	Other:	

Allergies

Social History

Smoking:	Never Smoker	Packs Per Day:	Quit In:
Alcohol:	Yes No	Drinks Per Day: or	Drinks Per Week:
Caffeine:	Cola/Soda	Coffee/Chocolate	Iced Tea / Other
Substance Abuse:	Yes No	Current user: Yes No	

Occupation

Immunizations (Please include the date or year vaccine was given, if known)

Flu	Pneumovax	Pprevnar	Tetanus	Other
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Family History (Please write name of illness/disease)

Father:	Mother:	Brothers:
Sisters:	Grandparents:	



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Review of Systems

Have you recently had any of the following symptoms?

Tire easily; weakness	Yes	No	High Blood Pressure	Yes	No
Recent weight changes	Yes	No	Palpitations	Yes	No
Night sweats	Yes	No	Vein Trouble	Yes	No
Persistent Fever	Yes	No	Heart Failure	Yes	No
Swelling of glands/lymph nodes	Yes	No	Pain in legs/Pain when walking	Yes	No
Frequent sinus infections	Yes	No	Chest pain/discomfort	Yes	No
Frequent colds	Yes	No	Ankle swelling	Yes	No
Nosebleeds	Yes	No	Difficulty swallowing	Yes	No
Post nasal drainage	Yes	No	Heartburn	Yes	No
Sore throat	Yes	No	Nausea	Yes	No
Hoarseness	Yes	No	Vomiting	Yes	No
Cough	Yes	No	Constipation	Yes	No
Bloody sputum	Yes	No	Diarrhea	Yes	No
Coughing sputum (phlegm)	Yes	No	Blood in urine	Yes	No
Wheezing	Yes	No	Thyroid trouble	Yes	No
Pain when breathing/coughing	Yes	No	Adrenal trouble	Yes	No
Shortness of breath	Yes	No	Steroid treatment	Yes	No
Difficulty breathing lying down	Yes	No	Diabetes	Yes	No
Bluish fingers or lips	Yes	No	Infertility	Yes	No
Change in nails or fingertips	Yes	No	Sensitivity to hot/cold	Yes	No
Snoring	Yes	No	Muscle weakness	Yes	No
Stop breathing while asleep	Yes	No	Pain in joints	Yes	No
Blood clot in leg or lungs	Yes	No	Swollen joints	Yes	No
Asbestos exposure	Yes	No	Stiffness	Yes	No
Collapsed lung	Yes	No	Headaches	Yes	No
Excessive sleepiness in daytime	Yes	No	Dizziness	Yes	No
Pneumonia as child	Yes	No	Fainting	Yes	No
Legs move while sleeping	Yes	No	Seizures	Yes	No
Loss of consciousness	Yes	No	Sleeplessness/Insomnia	Yes	No
Enlarged Heart	Yes	No	Depression	Yes	No
Heart Attack	Yes	No	Memory Loss	Yes	No



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Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

_____ to release healthcare information of the patient named above to:

Springfield Pulmonary Medicine & Sleep Clinic
Ramesh Chadalavada, M.D.
221 Northcrest Dr.
Springfield, TN 37172

This request and authorization applies to:

Healthcare information relating to the following treatment, condition or dates:

All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____