Chattanooga LIFESTYLE CENTER

PULMONARY REHABILITATION

Admission Application and Medical History

PATIENT: _____ Today's Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Marital Status: Married Single Divorced Widowed

Hospital Preference: _____

Primary Care Physician: _____ Cardiologist: _____

Highest level of education: _____ Preferred spoken language: _____

EMERGENCY CONTACT: _____ Relationship: _____

Home #: _____ Cell #: _____

EMPLOYER: _____

Occupation (current/most recent): _____

Current Work Status: Full Time Disabled Part Time Self-Employed Unemployed Retired

Other: _____ If retired, when: _____

How do you learn best? (Circle one): Seeing Hearing Doing No Preference

Have you experienced any kind of emotional/physical abuse? (past or present) Yes No

If yes, are you interested in referral information? Yes No

DIAGNOSIS HISTORY: (Indicate date of diagnosis/surgery)

Chronic Bronchitis: _____ COPD: _____ Asthma: _____

Bronchiectasis: _____ Emphysema: _____ Other: _____

FAMILY MEDICAL HISTORY: (Enter immediate family member's relationship and approximate age at diagnosis.)

Heart Attack: _____ Stroke: _____

High Blood Pressure: _____ Diabetes: _____

Any additional significant medical issues you currently have? _____

MEDICATIONS: **Please bring in complete list of current medications.**

ALLERGIES: (medication or food) _____

INSURANCE: Do you have medical insurance? Yes No

Primary: _____ Secondary: _____