Norton Cancer Institute
Multidisciplinary Lung Clinic - Downtown
676 S. Floyd St., Second Floor
Louisville, KY 40202
502- 629-4440

Dear Patient,

Welcome to Norton Cancer Institute Multidisciplinary Lung Clinic - Downtown. Thank you for allowing us to participate in your care. Before you come for your first visit, we would appreciate it if you would complete the forms provided in this packet so that we may better serve you.

The information you provide will help the doctor(s) assess your current condition and provide more insight into your past medical, social, and family history. Please fill it out to the best of your ability and return it to the front desk when you sign in for your office visit.

On the day of your office visit, please arrive 30 minutes early. In addition to your completed forms, remember to bring the following items with you:

- Current insurance cards
- Photo identification
- Complete written list of current medications
- X-rays, CT scans, and/or PET scans on a CD, and any records you received from your physician's office
- Co-pay for each physician specialist you are seeing if required by your insurance company
- Referral from your Primary Care Physician if required by your insurance company (HMO and POS insurance plans always require referrals)

If you do not have your referral, and one is required by your insurance plan, we will reschedule your appointment when you get the proper referral.

Thank you for your cooperation. We look forward to seeing you soon.

Sincerely,

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Name:____ Date of Birth____/____/____

Primary Care Physician:__________________ Referring Physician ___________________

Reason for Visit:____

Weight: _______ Height: _______

Medications: Dosage: Frequency:

1)_____________________ _______________________ _____________________

2)_____________________ _______________________ _____________________

3)______________________ ________________________ _____________________

4)______________________ _______________________ _____________________

For additional medications you may provide a list.

Allergies____

LATIX Y/N IODINE Y/N PACEMAKER Y/N AICD Y/N

Past Medical History: (Circle Y or N)

Y N Coronary artery disease/previous heart attack or angioplasty
Y N Diabetes
Y N Congestive Heart Failure
Y N High blood pressure
Y N Stroke
Y N Emphysema
Y N Asthma
Y N Hypothyroidism
Y N Reflux Disease
Y N Arthritis
Y N Hepatitis
Y N HIV
Y N Cancer ____
Other:____

Previous Surgery Date of Procedure

1)____ ___________________________

2)____ ___________________________

3)____ ___________________________

4)____ ___________________________

5)____ ___________________________

Family History (Major illness such as: coronary artery disease, stroke, emphysema, diabetes, aneurysm or cancer)

Father____
____

Mother____
____

Siblings____
____

Occupation:_______________________________ Marital Status_________________

Alcohol consumption: Y/N
Drinks per week_____, wine_____, beer_____, drinks containing alcohol_____

Smoker: Y/N _____ packs per day, how many years_______ Date quit_____________

Other forms of tobacco use:____

Review of Systems: (Circle Y or N)

General: Y N Sleep Changes
Y N Fatigue
Y N Weight loss or gain of more than10 pounds in a month

Skin: Y N Rashes
Y N Easy bruising

Head: Y N Dizziness
Y N Fainting
Y N Blurred Vision
Y N Headaches
Y N Hoarseness

Lung: Y N Short of breath
Y N Wheezing
Y N Coughing up blood
Y N Productive cough
Y N History of tuberculosis

Cardiac: Y N Murmurs
Y N Palpitations
Y N Chest Pain
Y N Trouble breathing at night
Y N Do you seep on more than one pillow

GI: Y N Nausea
Y N Vomiting
Y N Blood in stools
Y N Dark tarry stools
Y N Ulcers
Y N Constipation

Extremities: Y N Numbness
Y N Edema
Y N Varicose veins
Y N Vein stripping/ligation
Y N Cool or cold fingers/toes

Endocrine: Y N Cold intolerance
Y N Hyperthyroid
Y N Goiter

Musculoskeletal: Y N Joint Pain
Y N Swelling
Y N Limited range of motion
Y N Muscle cramps

Urinary: Y N Kidney stones
Y N Blood or pus in urine
Y N Difficult or painful urination
Y N Frequent/Urgent urination

Other: Y N Blood or clotting disorders
Y N Blood Transfusions
Y N Hepatitis

Pharmacy Name____

Address____

Phone Number____

Additional Comments:

____

____

____

____

____

Patient Signature:____

Date: ____/____/_____

Reviewed by____