Martha Jefferson Medical Associates
Dr. Alexander Schult
459 Locust Avenue, Charlottesville, VA 22902
T (434) 654-5290 • F (434) 654-5262

Patient Information

Patient Name (Last, First, Middle)		Social Security #		Today's Date ______/______/______
Street Address	City and State		Zip Code	
Home Phone ( )	Work Phone ( )		Date of Birth ______/______/______	
Sex F M	Marital Status M S W D			
Patient's Employer	Employer's Street Address	City and State	Zip Code	
Occupation	Student Status F = Full time P = Part time		School Name	

Insurance Information: Also, please provide your insurance card(s) so we may make a copy.

Name of Insurance		Responsible Party		
Subscriber's Name (Who holds the insurance?)		Relationship of Patient to Subscriber (please circle one) Self Spouse Parent Employer Child		
Subscriber's Social Security #	Subscriber's Street Address	City and State	Zip Code	
Subscriber's Home Phone ( )	Subscriber's Work Phone ( )	Subscriber's Date of Birth ______/______/______	Subscriber's Sex F M	
Subscriber's Employer	Employer's Street Address	City and State	Zip Code	

Emergency Contact Information:

Name	Street Address	City and State	Zip Code
Relationship to Patient	Daytime Phone Number ( )	Home Phone Number ( )	

Referring MD:____ Pharmacy: ______________________

Martha Jefferson Medical Associates

RESPIRATORY QUESTIONNAIRE

Name:________________________ Date of Appt.:____________________ Age:________

Occupational History: Please list entire work history, starting with present job and going back to first job. (You may use the back of this questionnaire if additional room is needed.)

Industry (or company & location)	From	To	Specify job

			Number of Years
A. Have you ever worked in a dusty job?	Yes	No	_______
1. In a mine?	Yes	No	_______
2. In a quarry?	Yes	No	_______
3. In a foundry?	Yes	No	_______
4. In a pottery?	Yes	No	_______
5. In a cotton, flax, or hemp mill?	Yes	No	_______
6. With Asbestos?	Yes	No	_______
7. In a brick plant?	Yes	No	_______
8. As a sandblaster?	Yes	No	_______
9. In the manufacture of glass, ceramics, or abrasives	Yes	No	_______
10. In other dusty jobs:	Yes	No	_______
Please specify________________________			
B. Have you ever worked with chemicals?	Yes	No	_______
1. Solvents?	Yes	No	_______
Specify________________________			
2. Acids?	Yes	No	_______
Specify________________________			
3. Lead?	Yes	No	_______
4. Plastics?	Yes	No	_______
Specify________________________			
5. TDI?	Yes	No	_______

II. Previous Illnesses

A. Have you ever had any of the following problems?		
1. Asthma?	Yes	No
2. Emphysema?	Yes	No
3. Chronic bronchitis?	Yes	No
4. Pneumonia?	Yes	No
5. Tuberculosis?	Yes	No
6. Pleurisy?	Yes	No
B. Have you ever had surgery on your chest or lungs?	Yes	No
If yes, specify ________________________		
C. Chest x-ray	Yes	No
Last One (date) ________________________		
Ever abnormal?	Yes	No
D. Tuberculosis skin test	Yes	No
Last one (date) ________________________		
Positive?	Yes	No

III. Symptoms

A. Cough

1. **Do you usually cough first thing in the morning?** **Yes No**
2. **Do you usually cough at other times during the day or night?** **Yes No**

(Skip 3 to 6 if answer to 1 and 2 is "No.")

3. **Do you cough on most days for as much as 3 months of the year?** **Yes No**
4. **For how many years have you had this cough?**
   Less than 2 years _______
   2 to 5 years ____________
   5 years or more _________
5. **Do you cough more on any particular day of the week?** **Yes No**
   If yes, which day? ____
6. **Do you cough during any particular season of the year?** **Yes No**
   If yes, which season? ____

B. Sputum

1. **Do you usually bring up phlegm, sputum or mucus from your chest first thing in the morning?** **Yes No**
2. **Do you usually bring up phlegm, sputum, or mucus from your chest at other times of the day or night** **Yes No**

(Skip 3 and 4 if the answer to l and 2 is "No.")

3. **Do you bring up phlegm, sputum, or mucus from your chest on most days for as much as 3 months of the year?** **Yes No**
4. **For how many years have you raised phlegm, sputum or mucus from your chest?**
   Less than 2 years _____________
   2 to 5 years ___________________
   5 years or more _______________

C. *Wheezing*

1. **Does your breathing ever sound wheezy?** **Yes No**
2. **Have you ever had attacks of shortness of breath with wheezing?** **Yes No**
3. **Have you ever had a feeling of tightness in your chest?** **Yes No**

(Skip 4 to 6 is answer to 1,2, and 3 is "No.")

4. **At what age did wheezing first occur? ________________**
5. **How frequently does wheezing occur?**
   Daily ____________ Nightly _____________ A few times per week _______
   A few times per month _________ A few times per year ________

D. *Breathlessness*

1. **Do you get short of breath when walking on ground level?** **Yes No**
2. **Do you get short of breath while walking up stairs?** **Yes No**
3. **How many flights of stairs can you climb up without stopping?**
   1 to 2? __________ 2 to 3? _____________ More than 3? _______________

E. Hemoptysis

1. **Have you ever coughed up blood from your chest?** **Yes No**
   If yes when was the last time this happened?
   ____

IV Smoking

A. Smoking (formerly)

1. **Have you ever smoked regularly?** **Yes No**

(Skip 2 to 7 if answer to 1 is "No." Answer if "Yes."

2. **How old were you when you started smoking?** **_______**
3. **For how many years did you smoke regularly?** **_______**
4. **When did you quit smoking? Month ___________ Year ________**
5. **How many cigarettes did you smoke per day?** **_______**
6. **How much tobacco did you usually smoke per week?** **_______**
7. **How many cigars did you usually smoke per day?** **_______**

V. Alcohol (currently)

1. **Do you currently consume alcohol?** **Yes No**

(Skip if answer to 1 is "No". Answer if "Yes")

2. **How much alcohol daily do you consume? __________________________**

VI. Travel

1. Have you traveled in or out of the United States within the last year? Yes No

If yes please list dates and location ____________________________________

____

VII. Hobbies

Please list hobbies and interests ____________________________________

____

VIII. Pets

1. Do you have pets inside? Yes No

If yes, please list ____

2. Do you have pets outside? Yes No

If yes, please list____

IX. Additional comments

Do you have any advanced directives?

(Please list name, address, and telephone number where they are located.)

No Yes Living Will ____

No Yes Durable Power of Attorney____

No Yes Other____

Surgery:

Type	Year

	Age	If Living Health	If Deceased Age at Death	Cause
Father				
Mother				
Brothers & Sisters				
Sons & Daughters				

Has any blood relative ever had: (Please circle and give relationship.)

Cancer: __________________________ Diabetes: ________________________ Stroke: __________________________

TB: ______________________________ Heart Trouble: ____________________ High blood pressure: _____________

PERSONAL HISTORY: Please Circle

ILLNESS:

Pneumonia	No	Yes
Influenza	No	Yes
Pleurisy	No	Yes
Rheumatic Fever	No	Yes
Heart Disease	No	Yes
Arthritis/Rheumatism	No	Yes
Any bone or joint disease	No	Yes
Epilepsy	No	Yes
Migraine headaches	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High/Low Blood Pressure	No	Yes
Fainting spells	No	Yes
Dizziness on change of position	No	Yes
Unconscious spells	No	Yes
Blurred/Double Vision	No	Yes
Any changes in vision	No	Yes
Do you wear glasses	No	Yes
Date of last exam _______		
Earaches	No	Yes
Ringing in ears	No	Yes
Decrease in hearing	No	Yes
Recurrent Nose bleeds	No	Yes
Sinus trouble	No	Yes
Hay fever/Asthma	No	Yes
Persistent Hoarseness	No	Yes
Difficulty swallowing	No	Yes
Enlarged glands	No	Yes
Recurrent sores in mouth	No	Yes
Soreness /bleeding when brushing	No	Yes
Chest pain	No	Yes
Angina pectoris	No	Yes
Pain in arm(s)	No	Yes
Night Sweats	No	Yes
Wake up at night short of breath	No	Yes
Recurrent stomach pains	No	Yes

Appetite: Good _____Fair _______ Poor ______

How many bed pillows do you use _______________

Hives or Eczema	No	Yes
Frequent Infections/Boils	No	Yes
AIDS	No	Yes
Gallbladder disease	No	Yes
Anemia	No	Yes
Jaundice	No	Yes
Bladder disease	No	Yes
Nausea or vomiting	No	Yes
Abdominal Cramping	No	Yes
Any blood in BM	No	Yes
Rectal pain with BM	No	Yes
Change in size, shape, color or texture of BM	No	Yes
Hemorrhoids/rectal disease	No	Yes
Colitis/other bowel disease	No	Yes
Pain on urination	No	Yes
Difficulty in starting urination	No	Yes
Getting up at night to urinate	No	Yes
How many times ___________		
Any blood in urine	No	Yes
Recurrent back pain	No	Yes
Backaches	No	Yes
Tingling/weakness hands/feet	No	Yes
Joint pains	No	Yes
Swelling of any joints, ankles, hands or feet	No	Yes
Redness/heat of any joints	No	Yes
Loss/change in sensation of hands/feet	No	Yes
Hot flashes	No	Yes
Inability to stand cold	No	Yes
Easy bruising	No	Yes
Any skin rash	No	Yes
Brittleness of nails	No	Yes
Dryness of Skin	No	Yes
Growth in neck or throat	No	Yes
Palpitations or fluttering heart	No	Yes
Belching or heartburn	No	Yes
Relieved by food or med	No	Yes

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MEDICATION LIST

Patient Name: ______________________________ Date: ______________________

Primary MD: _______________________________ Pharmacy: ___________________

Phone: ____________________________________ Phone: _____________________

Allergies: ____

____

____

____

____

DRUG NAME	FREQUENCY	START	STOP

Martha Jefferson Medical Associates

DEEMED CONSENT TO MEDICAL CARE, RELEASE OF INFORMATION AND PROTECTED HEALTH INFORMATION

Release & Assignment

I hereby consent to any necessary medical diagnosis and treatment for myself or above-named individual for whom I am legally responsible. The release of medical information to any insurance carrier and direct payment to the practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

Our Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any billing questions that we cannot answer directly, please call (434) 654-7794.

Martha Jefferson Medical Associates participates with and accepts assignment of insurance benefits of most insurance organizations. If your insurance company denies payment, you will be billed for those services and payment in full is due upon request. Of course, you are still responsible for the timely payment of deductibles, co-insurance and/or co-payments. Co-payments are due at the time of your visit. There is a $10.00 service fee to bill a guarantor for a co-pay. Martha Jefferson Medical Associates will accept cash, check, money order, MasterCard, Amex and Discover. If your check is returned by the bank, there will be a $25.00 return check fee added to your account. We also charge a $25.00 fee for no-show appointments. Please call in advance to cancel an appointment.

If payment is not received, your account may be referred to an outside collection agency. If your account is referred to collections, you will be responsible for all agency and/or attorney fees associated with collection. You will also be given a 30-day notice of discharge from the practice. ____________________ Guarantor, please initial.

If your insurance company requires a referral, you are responsible for obtaining the referral. If the referral is not obtained, you can be held responsible for payment in full by the specialist for the date of service.

Notice of Privacy Practices

Martha Jefferson Medical Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning our acknowledgment and consent. Please ask for your copy today.

Acknowledgement and Consent

I have read and understand the above financial policy. I understand that Martha Jefferson Medical Associates is authorized to use and disclose health information about the patient or treatment, payment and healthcare operation's purposes consistent with its Notice of Privacy Practices, including discussions with family members (unless otherwise requested).

It is permissible to leave test results on my answering machine: ☐ Yes ☐ No

It is permissible to leave test results with: ☐Patient ☐Spouse ☐Parent ☐Child ☐Sibling
☐ Other: ______________________ (please specify)

Signed: ________________________________ Date: ______________