

Patient Name: _____

Demographic Information

Name: _____

Date of Birth: ____/____/____

Mailing Address: _____

Home Phone: _____

Work Phone: _____

Cell Number: _____

Email Address: _____

Preferred method of contact (circle one): Phone Email Mail

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

Preferred Site (circle one): Mpls Edina Woodbury

MLC Physician

Do you see a Minnesota Lung Center Provider? Yes No Provider Name _____

Primary Care Provider

Name: _____ Practice: _____ Phone: _____ (if known)

Secondary Provider (if applicable):

Name: _____ Practice: _____ Phone: _____ (if known)

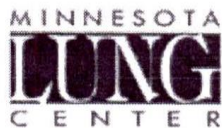
Pharmacy Information

Name: _____ Location: _____ Phone: _____ (if known)

Medical Records Release

Can we obtain medical records to confirm medical history information gathered? Yes No

Patient Signature: _____ **Date:** _____



Patient Name: _____

Past Medical History (check each condition that applies, include start date)

Respiratory System:

- Asthma _____
- COPD _____
- Pulmonary Fibrosis _____
- Emphysema _____
- Chronic Bronchitis _____
- Tuberculosis or TB exposure _____
- Pneumonia _____
- Sarcoidosis _____
- Recurrent Sinusitis _____

Mental Health:

- Depression _____
- Anxiety _____
- Mental Illness _____

Endocrine:

- Diabetes _____
- Thyroid Disease _____

Musculoskeletal System:

- Osteoarthritis _____
- Osteoporosis _____
- Osteopenia _____
- Back Pain _____
- Degenerative Disc Disease _____
- Arthritis _____

Nervous System:

- Restless Leg Syndrome _____
- Fibromyalgia _____
- Migraines _____
- Headaches _____
- Parkinsons _____
- Seizures _____

Cardiovascular System:

- High Cholesterol _____
- High Blood Pressure _____
- Heart Disease _____
- Atrial Fibrillation _____
- Angioplasty/Stents _____
- Heart Failure _____
- Stroke/TIA _____
- DVT/Blood Clot _____
- Pulmonary Emboli _____
- Abnormal Bleeding _____
- Chest Pain _____
- Irregular Heartbeat _____

Gastrointestinal System:

- GERD _____
- Peptic Ulcer _____
- Diverticulitis _____
- IBS _____
- Diarrhea _____
- Constipation _____

Immune/Lymphatic System:

- HIV/AIDS _____
- Hepatitis _____
- Lupus _____
- Rheumatoid Arthritis _____

Eyes, Ears, Nose, & Throat:

- Glaucoma _____
- Environmental /Seasonal Allergies _____
- Hearing Loss _____
- Cataracts _____
- Macular Degeneration _____

Urinary / Reproductive System:

- Kidney Stones _____
- BPH _____
- Overactive Bladder _____
- Urinary Incontinence _____
- Kidney Disease _____
- Surgically Sterile _____
- Hysterectomy _____

Other:

- Sleep Apnea _____
- Insomnia _____

Please List All Other Major and/or Minor Illnesses, include start dates:

Please List All Surgeries and Dates:



Patient Name: _____

Cancer History

Have you had cancer? Yes No If yes, what type and when? _____

Substance History

Do you Currently Smoke ? Yes No If Quit, When? _____

How many years smoking? _____ Average cigarettes per day during this time? _____

Alcohol Consumption: _____ # Drinks per Day Week Month Year

Recreational Drugs? Yes No Type: _____

Allergies No Known Allergies (Please check box if applies)

Name of Allergen or Medication	Type of Reaction

Release of Information

Minnesota Lung Center Research Department

920 East 28th Street, Suite 700

Minneapolis, MN 55407

Phone #: 952-852-5324

Fax #: 612-863-7309

Clinic(s) Information

RE: _____

(Patient's Name)

(Date of Birth)

This is your full and sufficient authorization, pursuant to Minnesota Statute, (Section 144.292, Subd.6) (Health Records Act re-codified 2007 MN Statutes 144.29 through 144.298).

To release to: Minnesota Lung Center Research Department and/or their representatives,

All medical records generated through your facility: From: _____ to _____ present _____, (including but not limited to that which involves treatment for alcohol or drug abuse, sickle cell anemia, mental problems or HIV) and specifically including any neurological/psychological information Maintained while I was a patient at your facility on any date, with the following exceptions: _____

The information is released for the purpose of: Continuation of Care – Clinical Trial

This authorization specifically includes records prepared prior to the date of this authorization. I understand that the protected health information described above may be re-disclosed and no longer protected by federal and state privacy regulations if further disclosed by the recipient.

I understand that I may revoke this consent in writing at any time, but that such revocation may adversely affect the course of the proceeding requiring these records. I also understand that I may refuse to sign this authorization, and that such refusal will not affect my treatment, payment, enrollment, or eligibility of benefits. **However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions.** Upon fulfillment of the above stated purpose, this consent will automatically expire without my express revocation. **A photocopy, scanned, e-mailed, or electronically signed copy of this authorization by the bearer will be treated in the same manner as the original.** Conversations by the bearer of this authorization with physicians are authorized by this release form.

Signature of patient/guardian

Date

Relationship to patient (if guardian)

Reason patient is unable to sign (if guardian)