NAME:_______________________

CHARLESTON PULMONARY ASSOCIATES, P.A.
CAROLINA SLEEP SPECIALISTS, P.A.

125 DOUGHTY STREET SUITE 200 CHARLESTON, SC 29403 PHONE 843-577-6791 FAX 843-577-0553
897 VON KOLNITZ ROAD SUITE 104 MT. PLEASANT, SC 29464

PLEASE CIRLE ANSWERS

DO YOU SMOKE: YES / NO **FORMER SMOKER:** YES / NO

YEARS SMOKED: ____ **START YEAR:** _____ **END YEAR(if former smoker):**______

IF YOU SMOKE/SMOKED, WHEN DID YOU LAST SMOKE: ___________

NUMBER OF CIGARETTES/DAY:____________ **YEARS SMOKED:** __________

DO YOU SMOKE CIGARS: YES / NO **CHEW TOBACCO**: YES / NO

USE SNUFF:YES / NO

DO YOU DRINK ALCOHOL: YES / NO

IF YOU DRINK ALCOHOL, HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

NEVER MONTHLY OR LESS 2-4 TIMES A MONTH
2-3 TIMES A WEEK 4 OR MORE TIMES A WEEK

HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST YEAR?

1-2 DRINKS 3-4 DRINKS 5-6 DRINKS 7-9 DRINKS 10+ DRINKS

HOW OFTEND DID YOU HAVE 6 OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?

NEVER LESS THAN A MONTHLY MONTHLY
WEEKLY DAILY OR ALMOST DAILY

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Advanced Directives Form

Do you have any of the following:

Power of Attorney **Yes/ No**

Living Will **Yes/ No**

DNR Order **Yes/ No**

Medical Power of Attorney **Yes/No**

☐ **I don't wish to discuss advanced directives.**

***If you have a copy of your power of attorney documents, we are happy to scan to your chart.**

Home Safety

Are you abused/mistreated in the home? Yes/No

Do you feel safe at home? Yes/No