NAME:_____

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

125 Doughty Street, Suite 200 Charleston, SC 29403
1300 Hospital Drive Suite 320 Mt Pleasant, SC 29464
2061 US-52 Moncks Corner, SC 29461
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James J. Carswell IV, M.D.
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Dr. Jason Huet, M.D.
Michelle Young, PA

John A. Mitchell, M.D.
Jason E. Gunn, M.D.
Craig Schuring, D.O.
Nicole Ferroni, NP

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: _____

HOW MANY PACKS PER 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 DIRINKS 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**◯ **POA Name:**

Living Will ◯**Yes/ No**◯ _____

DNR Order ◯**Yes/ No**◯ **Medical POA:**

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 ◯ ◯