

Date _____

Name _____ Age _____ DOB _____

Referring Physician _____

What problem brings you to see us today?

Have you had any of the following?

- Shortness of breath
- Chest pain
- Dry cough
- Cough productive of phlegm
- Coughing up blood
- Wheezing

Past Medical History:

Check any of the following illnesses with which you have been diagnosed and provide details in the space provided.

- Asthma
- Blood clot in leg (DVT)
- Cancer (specific type) _____
- Cirrhosis
- Congestive heart failure (weak heart, enlarged heart)
- Coronary artery disease (angina, heart attack, heart blockages)
- Diabetes
- Emphysema or chronic bronchitis
- Gallbladder disease
- Gastroesophageal reflux disease (GERD)
- Hepatitis
- High blood pressure
- HIV/AIDS
- Peptic ulcer disease (stomach ulcers)
- Pneumonia
- Pulmonary embolus (blood clot traveled to lung)
- Sleep apnea
- Stroke
- Tuberculosis
- Thyroid disease (hypertension, hypothyroidism)

List any other medical illnesses/diagnoses (use back of page if necessary):

Patient Name _____

Past Surgical History:

List all surgeries you have had in the past and their approximate dates:

Medications:

List all medications you currently take. Include dosage and frequency. Please include all inhalers, insulin and over the counter medications.

Immunization History:

List approximate date of last immunization. Write N/A if you have never had the immunization.

Influenza “flu shot” _____

Pneumovax “pneumonia shot” _____

Tetanus _____

Allergies: check if no known drug allergies

List any drugs you cannot take and why (rash, swelling, nausea. etc.)

Patient Name _____

Family Health History:

	<i>Lung Disease</i>	<i>Heart Disease</i>	<i>Other Illnesses</i>	<i>Cause of Death</i>
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____

Habits:

Did you ever smoke? Yes No If yes, when did you start? _____

Do you still smoke? Yes No If no, when did you stop? _____

How many packs per day? _____

Do you drink any alcohol currently? Yes No

If yes, approximately how much do you drink? _____

Do you have any past history of heavy alcohol use? Yes No

Do you have any history of abusing prescribed or non-prescribed drugs? Yes No

Which substance(s)? _____

Last time used? _____

Have you ever abused IV drugs? Yes No

Social History:

Marital status: Single Married Divorced Widowed

How many children do you have? _____

Who should be contacted in case of an emergency? _____

Relationship _____ Phone Number _____

What is your occupation now or prior to retirement? _____

How long at occupation? _____

Have you been exposed to any of the following at work?

Asbestos

Silica (sand, sandblasting)

Coal Dust

Chemicals (provide details) _____

Bird Feathers

Patient Name _____

Review of Systems:

Please check if you have had any of the following symptoms or findings recently

Yes	No	General	Yes	No	Cardiopulmonary	Yes	No	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain (w/exertion)	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain (at rest)	<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling
<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath (w/exertion)	<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Tend to be too hot	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath (at rest)	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	Tend to be too cold	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath (lying down)	Yes	No	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (heart racing)	<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump/mass
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	Yes	No	Heme/Onc
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Severe fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Thirsty	<input type="checkbox"/>	<input type="checkbox"/>	Pain on deep breathing	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	More hungry than normal	<input type="checkbox"/>	<input type="checkbox"/>	Sleep with more than one pillow under your head at night	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands
Yes	No	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in the feet	Yes	No	Genitourinary
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headache	Yes	No	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	Burning urination
<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent awakening	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Fainting/passing out	<input type="checkbox"/>	<input type="checkbox"/>	Waking up too early	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Weakness arms/legs	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Weak urine stream
<input type="checkbox"/>	<input type="checkbox"/>	Numbness arms/legs	<input type="checkbox"/>	<input type="checkbox"/>	Leg discomfort/restlessness occurring in the evening	<input type="checkbox"/>	<input type="checkbox"/>	Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Heavy menstrual bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Severe daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	Impotence
Yes	No	EENT	<input type="checkbox"/>	<input type="checkbox"/>	Interruptions in breathing while asleep	Yes	No	Psychiatric
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Waking with shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Color blindness	Yes	No	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Pain or difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Ringings in ears	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/indigestion (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Dark, tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Mouth Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Vomited blood	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Mass or lump in neck	<input type="checkbox"/>	<input type="checkbox"/>	Reflux			
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing						
<input type="checkbox"/>	<input type="checkbox"/>	Post nasal drip						

I personally reviewed all the systems listed above. _____ Signature _____ Date _____