# *Pulmonary & Critical Care Specialists*

*Pulmonary • Critical Care • Sleep Disorders*

**Hany Jacob, MD, FCCP, DABSM**
Danielle Geroski, MSN, APRN-CNP
Kelcee Hall, MSN, APRN-CNP
Sara Zaciewski, MSN, RN

**Name:_____DOB: __/__/____Age:_____Date:_____**

**Pharmacy: _____PCP: _____Referring Dr: _____**

**Chief Complaint: _____**

**When did problem begin?_____**

**Do you have home Oxygen?_____**

**Medical Equipment Company Used: _____**

**Your Medical History**

_____ Allergic Rhinitis
_____ Angina
_____ Arthritis
_____ Asthma
_____ Bronchitis
_____ Cancer Type _____
_____ COPD
_____ Congestive Heart Failure
_____ Depression
_____ Dizziness
_____ Diabetes (Insulin or Non-Insulin Dependent)
_____ Emphysema
_____GERD
_____ Headache
_____ Heart Attack
_____ High Blood Pressure
_____ Kidney Stones
_____ Liver Disease/Hepatitis
_____ Low Blood Pressure
_____ Pneumonia
_____ Prior Intubations
_____ Shortness of Breath
_____ Sinus
_____ Stroke
_____ Thyroid (Hypo/Hyper)
_____ Tuberculosis
_____ Ulcers

Other: _____

**Surgical History (With Approximate Date)**

_____ Adenoids/Tonsils
_____ Angioplasty
_____ Appendix
_____ Bypass
_____ Gall Bladder
_____ Stents
_____ Heart
_____ Hernia
_____ Internal Cardiac Defibrillator (ICD)
_____ Lung (Surgery or Biopsy)
_____ Pacemaker
_____ Stomach

Other: _____

**Name:** _____ **DOB:** _____ **Date:** _____

## Medications/Supplements

| Name | Dosage (mg) | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Allergies with Reactions

| | |
|---|---|
| | |
| | |
| | |
| | |

## Family History

_____ Angina
_____ Headaches
_____ Arthritis
_____ Heart Attack
_____ Asthma
_____ High Blood Pressure
_____ Cancer Type: _____
_____ Insomnia
_____ Kidney Disease
_____ CHF
_____ Liver Disease/Hepatitis
_____ COPD
_____ Narcolepsy
_____ Depression
_____ Obstructive Sleep Apnea
_____ Diabetes
_____ Restless Leg Syndrome
_____ Emphysema
_____ Thyroid (Hypo or Hyper)

Other:
_____
_____

**Name:** _____ **DOB:** _____ **Date:** _____

**Physical Activity**

- Are you: _____ Active _____ Somewhat Active _____ Not Active
- Height: _____ Weight: _____
    - Has your weight changed? ____Yes ____ No
        - If yes, how much? _____
        - If yes, over how long? _____

**Social History**

- Caffeine Use: ____Yes ____ No
    - If yes, how much per day? _____
- Do you smoke? ____Yes ____ No
    - If yes, when did you start smoking? _____ Packs per day? _____
    - If former smoker, when did you quit? _____ How long did you smoke? _____
- Do you use alcohol? ____Yes ____ No
    - If yes, how much per day? _____
- Illegal Drug/Substance Abuse? ____Yes ____ No
    - If yes, please explain: _____

**Psychosocial History**

- Marital Status: _____ Married _____ Divorced _____ Single _____ Widow
- Family Support: _____ Excellent _____ Good _____ Fair _____ Poor _____ None
- Occupation: _____ Retired beginning: _____
- Shift Worker: ____Yes ____ No
    - If yes, what shifts? _____
- Exposure to: _____ Fumes _____ Chemicals _____ Dust _____ Asbestosis
- Do you have job stress? _____ Yes _____ No

**Name:** _____ **DOB:** _____ **Date:** _____

**Review of Systems** In the last month, have you had any of the following symptoms?

| | Admits | Denies |
|---|---|---|
| **General** | | [ ] |
| Loss of energy | [ ] | |
| Fevers/Chills | [ ] | |
| Night sweats | [ ] | |
| **Skin** | | [ ] |
| Rashes | [ ] | |
| Change in skin color | [ ] | |
| Unhealed sores | [ ] | |
| **Blood** | | [ ] |
| Unusual bleeding | [ ] | |
| Easy bruising | [ ] | |
| Anemia | [ ] | |
| Enlarged glands | [ ] | |
| **Endocrine** | | [ ] |
| Heat/Cold intolerance | [ ] | |
| Hair growth/loss | [ ] | |
| Increased thirst | [ ] | |
| Increased hunger | [ ] | |
| **Eyes/Ears/Mouth** | | [ ] |
| Vision trouble | [ ] | |
| Double vision | [ ] | |
| Eye pain | [ ] | |
| Hearing trouble | [ ] | |
| Ringing in ears | [ ] | |
| Dizziness | [ ] | |
| Dental problems | [ ] | |
| Difficulty swallowing | [ ] | |
| Mouth sores | [ ] | |
| Hoarseness | [ ] | |
| **Lungs/Nose** | | [ ] |
| Nose bleeds | [ ] | |
| Cough | [ ] | |
| Runny nose | [ ] | |
| Shortness of breath | [ ] | |
| Wheezing | [ ] | |

| | Admits | Denies |
|---|---|---|
| **Cardiac** | | [ ] |
| Heart problems | [ ] | |
| Chest pain | [ ] | |
| Heart murmurs | [ ] | |
| Heart attack | [ ] | |
| Fainting | [ ] | |
| Difficulty laying flat | [ ] | |
| **Gastrointestinal** | | [ ] |
| Abdominal pain | [ ] | |
| Heartburn | [ ] | |
| Nausea/Vomiting | [ ] | |
| Diarrhea | [ ] | |
| Constipation | [ ] | |
| Blood in stool | [ ] | |
| **Urinary** | | [ ] |
| Burning while urinating | [ ] | |
| Blood in urine | [ ] | |
| Increased urine | [ ] | |
| Flank pain | [ ] | |
| Trouble in start/stop | [ ] | |
| **Muscle/Skeleton** | | [ ] |
| Joint pain | [ ] | |
| Morning stiffness | [ ] | |
| Back problems | [ ] | |
| **Neurologic** | | [ ] |
| Blackouts | [ ] | |
| Seizures | [ ] | |
| Frequent headaches | [ ] | |
| Muscle weakness | [ ] | |
| Trouble talking | [ ] | |
| Balance problems | [ ] | |
| Memory problems | [ ] | |
| **Emotion** | | [ ] |
| Mood swings | [ ] | |
| Crying spells | [ ] | |
| Depression | [ ] | |