Pulmonary & Critical Care Specialists

Pulmonary • Critical Care • Sleep Disorders

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Name:_______________________________________ **DOB:**____/____/_____ **Age:**_____ **Date:**____/_____/______

Primary Care Physician: ____

Chief Complaint:______________________________ **When did the 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

Please circle all that apply

Father: COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Mother: COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Son(s): COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Daughter(s): COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Grandmother (P): COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Grandfather (P): COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Grandmother (M): COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

Grandfather (M): COPD OSA Heart Attack Cancer (Type:) Diabetes Heart disease

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?

	Y	N		Y	N
General			**Cardiac**		
Loss of energy			Chest pain		
Fevers/Chills			Heart murmurs		
Night sweats			Heart attack		
			Fainting		
Skin			Difficulty laying flat		
Rashes					
Skin color change			**Stomach**		
Unhealed sores			Abdominal pain		
			Heartburn		
Blood			Nausea/Vomiting		
Unusual bleeding			Diarrhea		
Easy bruising			Constipation		
Anemia			Blood in stool		
Enlarged glands					
			Urinary		
Endocrine			Burning while urinating		
Heat/Cold intolerance			Blood in urine		
Hair growth/loss			Increased urine		
Increased thirst			Flank pain		
Increased hunger			Trouble in start/stop		
Eyes/Ears/ Mouth			**Muscle/ Skeleton**		
Vision trouble			Joint pain		
Double vision			Morning stiffness		
Eye pain			Back pain/problems		
Hearing trouble					
Ringing in ears			**Neurologic**		
Dizziness			Blackouts		
Difficulty swallowing			Seizures		
Mouth sores			Headaches		
Hoarseness			Muscle weakness		
			Trouble Talking		
Lungs/Nose			Balance Problems		
Nose bleeds			Memory Problems		
Cough					
Runny Nose			**Emotional**		
Shortness of breath			Mood swings		
Wheezing			Crying spells		
			Depression		