Name: _____ **Age**: _____ **Date**: _____ **Ref. Phy**. _____

Please help us find out about you by filling out the **PATIENT** side of this form on pages 1-3. Please leave the **CLINICIAN** side blank.

PATIENT

CLINICIAN

Why are you here to see a pulmonary (lung) doctor? **CC**

_____

_____

_____

Currently, do you experience any of these problems? **HPI**

- ☐ Unable to catch your breath
- ☐ Wheezing
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Unable to sleep lying flat or with 1 pillow
- ☐ Sudden onset of difficulty breathing
- ☐ Night sweats
- ☐ Coughing up blood
- ☐ Chest pains or pressure
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Swollen legs
- ☐ Heart failure
- ☐ Blue lips or fingernails
- ☐ Leg cramps when you walk

Have you ever had:

- ☐ A pulmonary stress test
- ☐ An electrocardiogram (EKG)
- ☐ A pulmonary function test (spirometry)
- ☐ A bronchoscopy or lung biopsy
- ☐ Lung surgery, including complete or partial removal
- ☐ Heart surgery
- ☐ Lung cancer
- ☐ Exposure to tuberculosis or had tuberculosis
- ☐ Pneumonia
- ☐ Blood clot

Are you currently, or in the past, being treated for any illness? If so please list them. **Past Med Hx**

1. _____
2. _____
3. _____
4. _____

Have you ever had any operations? Any injuries: **Past Surg Hx**

1. _____
2. _____
3. _____
4. _____

Name:_____ **Date**: _____

Check if any close family members (parents, brothers, sisters, children) have: **Family Hx**

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heartburn
- ☐

Are there any other health problems in your family:

_____

Marital Status S M W D **Social Hx**

With whom do you live? _____
What is your occupation? _____
What are your leisure activities? _____
_____
What is your education level? _____

Tell us about your risk of lung disease. Please check if you: **Risk Factors**

- ☐ Worked around toxic chemicals or substances
- ☐ Have asthma
- ☐ Ever smoked
- ☐ Live with someone who smokes
- ☐ Asbestos exposure

Do you exercise (including walking)?

☐ Yes ☐ No

Has a close family member had lung cancer, tuberculosis or emphysema? ☐ Yes ☐ No
Who? _____
If you are a woman, have you passed menopause (change of life)?

☐ Yes ☐ No If yes, at what age: _____

Do you take estrogen replacement: ☐ Yes ☐ No

Please tell us anything else about your lungs: _____
_____
_____

Health Habits:

Do you smoke: ☐ Yes ☐ No
How many packs per day? _____ How many years? _____
If you no longer smoke, **when did you quit?** _____
How much alcohol do you drink? _____
Do you use any **recreational drug(s)?** ☐ Yes ☐ No
If yes, please list: _____

Are you allergic to any medications? ☐ Yes ☐ No **Allergies**
List medication allergies and your reaction:

1. _____
2. _____
3. _____
4. _____

Do you have hay fever: ☐ Yes ☐ No
What is your reaction? _____
_____

Name: _____ **Date:** _____

Have you had the following vaccinations:

Vaccinations

- ☐ Influenza (flu shot) Annually
- ☐ Pneumococcal (pneumonia) vaccine

Please tell us about your medicines (name, dose or strength, how many times per day). Include any over-the-counter drugs.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please circle any symptoms you have:

REVIEW OF SYSTEMS

Lack of energy; daytime sleepiness; trouble sleeping; snoring; loss of appetite; weight changes; fevers — **CONSTITUTIONAL**

Eye problems such as double or blurred vision; glaucoma; cataracts; hearing problems; buzzing or ringing in your ears, allergies; hay fever; sinus problems — **HEENT**

Blood pressure or heart problems — **CARDIAC**

Asthma; tuberculosis — **PULMONARY**

Stomach problems; heartburn; indigestion; change in bowel habits; bloody or tarry stools; jaundice; liver problems, ulcers, gallstones. — **DIGESTIVE**

Urinary frequency; infections; stones; bladder
Men: Prostate problems; nighttime urination
Women: Abnormal menstrual periods. Could you be pregnant? ☐ Yes ☐ No — **URINARY**

Joint pain with swelling or redness; arthritis; back pain; Muscle aches or tenderness; gout — **MUSCULOSKELETAL**

Rash, itching or other skin problems — **DERMATOLOGICAL**

Women: breast lump(s); recent mammogram; pap smear and/or pelvic exam — **FEMALE REPRODUCTIVE**

Paralysis (even temporary); stroke; numbness; loss of balance; seizures; loss of memory; headaches — **NEUROLOGIC**

Unusual thoughts; nervousness; crying or sadness; depression; suicide attempts or thoughts of suicide — **PSYCHIATRIC**

Thyroid disorder; diabetes; excess thirst, hunger, or urination — **ENDOCRINE**

Bleeding; easy bruising; risk factors for HIV; anemia; cancer — **HEMATOLOGIC**