

Printed Patient Name: _____ Date of Birth: _____

REASON FOR VISIT: _____ Today's Date: _____

Have you ever been diagnosed with a lung problem? YES NO

If yes (circle / complete): ASTHMA COPD EMPHYSEMA CHRONIC BRONCHITIS PNEUMONIA

PNEUMOTHORAX Idiopathic Pulmonary Fibrosis BRONCHIETASIS

OTHER: _____

MARK ALL THAT APPLY:

___ Hospitalization for a Lung problem:

Year _____ Diagnosis _____ Duration _____ Other: _____

___ Other Hospitalizations:

Year _____ Diagnosis _____ Duration _____ Other: _____

Year _____ Diagnosis _____ Duration _____ Other: _____

Year _____ Diagnosis _____ Duration _____ Other: _____

___ Previous Chest Surgery:

Year _____ Diagnosis _____ Duration _____ Other: _____

___ Other Previous Surgeries:

Year _____ Diagnosis _____ Duration _____ Other: _____

Year _____ Diagnosis _____ Duration _____ Other: _____

Year _____ Diagnosis _____ Duration _____ Other: _____

___ Emergency Room Visits:

Year _____ Diagnosis _____ Duration _____ Other: _____

Year _____ Diagnosis _____ Duration _____ Other: _____

___ Previous Chest X-ray: Where _____ Most Recent Date _____

___ Previous Pulmonary Function Test: Where _____ Most Recent Date _____

___ Other Diagnostic Studies: (eg. CT Scan, Bronchoscopy, etc.)

Study: _____ Where: _____ Most Recent Date _____

Study: _____ Where: _____ Most Recent Date _____

**Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.*

OTHER PHYSICIANS THAT I HAVE SEEN:

___ Internist Name: _____ 1st Visit: _____ Last Visit: _____

___ Cardiologist Name: _____ 1st Visit: _____ Last Visit: _____

___ Allergist Name: _____ 1st Visit: _____ Last Visit: _____

___ Pulmonologist Name: _____ 1st Visit: _____ Last Visit: _____

___ ENT Name: _____ 1st Visit: _____ Last Visit: _____

___ Orthopedist Name: _____ 1st Visit: _____ Last Visit: _____

___ Surgeon Name: _____ 1st Visit: _____ Last Visit: _____

___ Neurosurgeon Name: _____ 1st Visit: _____ Last Visit: _____

___ GI Name: _____ 1st Visit: _____ Last Visit: _____

___ Urologist Name: _____ 1st Visit: _____ Last Visit: _____

___ OB/GYN Name: _____ 1st Visit: _____ Last Visit: _____

___ Psychiatrist Name: _____ 1st Visit: _____ Last Visit: _____

___ Other Name: _____ 1st Visit: _____ Last Visit: _____

Patient Name: _____

ONGOING/REOCCURRING MEDICAL PROBLEMS: _____

MEDICATION ALLERGIES: No Known Allergies If yes, complete below:

Drug Name	Reaction

VACCINES RECEIVED: (Mark all that apply)

	NAME	Describe Reaction if Any.
<input type="checkbox"/>	Flu Vaccine	
<input type="checkbox"/>	Pneumonia Vaccine	
<input type="checkbox"/>	PPD	
<input type="checkbox"/>	BCG	
<input type="checkbox"/>	Zostavax (Shingles Vaccine)	

CURRENT MEDICATIONS FOR LUNGS: (Include INHALERS and OXYGEN)

NAME	DOSE	FREQUENCY	INDICATION

OTHER CURRENT MEDICATIONS:

NAME	DOSE	FREQUENCY	INDICATION

ENVIRONMENTAL ALLERGIES: (Mark all that apply)

_____ Do you have seasonal allergies? ___ Spring ___ Summer ___ Fall ___ Winter

_____ Have you ever had skin testing for allergies? When _____

_____ Are you exposed to animals and does this exposure cause symptoms?

_____ Cats Symptoms: _____

_____ Dogs Symptoms: _____

_____ Birds Symptoms: _____

_____ Rodents Symptoms: _____

Patient Name: _____

Mark All that Currently Apply:

General Questions	Wheezing
Intermittent cough (not related to common cold)	Following a common cold
Frequent cough in the morning	With exercise
Sputum production # _____ tablespoons per day	Seasonally
Coughing up blood	Shortness of Breath
Chest congestion / tightness	During strenuous exercise
Positive TB skin test in the past	During moderate exercise
Exposure to TB	During normal activity
Pneumonia – When	Awaken at night
	While at rest

Smoking History (Mark and Complete all that apply)

Never Smoked	
Quit Smoking When - _____	Average Packs / Day
	Number of Years Smoked
Currently Smoking	Average Packs / Day
	Number of Years Smoked

Do You Currently Exercise? NO If Yes, List Type and Duration: _____

What is the most strenuous activity you have done this past week? _____

Birthplace: _____

Education: (Mark Highest Level Completed) Primary Secondary Undergraduate Post Graduate

Occupation / Profession: _____

Retired: YES NO

HAVE YOU EVER WORKED IN THE FOLLOWING OCCUPATIONS OR ENVIRONMENTS? (Mark all that apply):

Railroad Worker	Carpenter	Textile Worker
Cotton Mill Worker	Woodworker	Painter
Foundry Worker	Mica Worker	Pottery Worker
Pipe Coverer	Insulation Worker	Smelter
Farmer	Silica Dust	Mining
Talc Worker	Sandblaster	Beryllium Worker
Aluminum Worker	Pulp Mill Worker	Plastic Worker

SLEEP HISTORY: (Rank each situation according to the scale below)

- Scale:** 0 – Would Never Dose
 1 – Slight Chance of Dosing
 2 – Moderate Chance of Dosing
 3 – High Chance of Dosing

SITUATION	RANK			
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting Inactive in a Public Place (eg. Theater, waiting room, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	Cardiovascular	Genitourinary
Weight Changes	Chest Pain	Pain with Urination
Sleeping Problems	Heart Attack	Frequent Urination
Loud Snoring	Heart Murmur	Blood in Urine
Fevers/Chills/Sweats	Palpitations	Kidney Stones
Skin	Irregular Heart Beat	Musculoskeletal
Skin Rash	Shortness of Breath w/Walking	Joint Pain/Swelling
Itching	Dizziness	Back Pain
New Skin Marks/Spots	Swelling of Feet/Ankles	Muscle Pains/Aches
Head/Eyes/Ears/Nose/Throat	Gastrointestinal	Neurological
Visual Problems/Changes	Nausea / Vomiting	Numbness
Itching Eyes/Nose	Vomiting Blood	Tingling
Nose Bleeds	Difficulty Swallowing	Weakness/Paralysis
Drainage From Nose	Heartburn/Indigestion	Tremors
Sinus Infections	Abdominal Pain	Seizures
Hoarseness	Constipation	Psychological
Sore Throats	Diarrhea	Depression
Headaches	Bloody/Black Stools	Anxiety/Panic Attacks
Respiratory	Other Medical Problems Not Listed:	
Coughing		
Wheezing		
Shortness of Breath		
Bronchitis		
Frequent Colds		
Coughing Up Blood		

Patient Signature: _____ Date: _____