

Name:

Date:

DOB:

Age:

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Please help us find out about you by filling out the "Patient" side of this form on pages 1-3. If you of the questions, ask a family member or one of our staff to assist yo

Please leave "Clinician" side blank.

PATIENT	CLINICIAN
<p>Why are you here to see a pulmonary (lung) doctor?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Check off any lung or breathing problems or symptoms</p> <ul style="list-style-type: none"> <input type="checkbox"/> Unable to catch your breath <input type="checkbox"/> Wheezing <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Unable to sleep laying flat or with one (1) pillow <input type="checkbox"/> Sudden onset of difficulty breathing <input type="checkbox"/> Night sweats <input type="checkbox"/> Coughed up blood <input type="checkbox"/> Chest pains or pressure <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dizziness <input type="checkbox"/> Swollen legs <input type="checkbox"/> Heart failure <input type="checkbox"/> Blue lips or fingernails <input type="checkbox"/> Leg cramps when you walk <p>Have you ever had:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A pulmonary stress test <input type="checkbox"/> An electrocardiogram <input type="checkbox"/> A pulmonary function or spirometry test <input type="checkbox"/> A bronchoscopy or bronchial/lung biopsy <input type="checkbox"/> Lung surgery, including complete or partial removal or a lung <input type="checkbox"/> Heart surgery <input type="checkbox"/> Lung cancer <input type="checkbox"/> Exposure to tuberculosis or had tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Blood clot <p>Are you being treated now or have been treated for any illnesses? Please list them.</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>Have you ever had any operations? Any injuries?</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>Check if any close family member (parents, brothers and sisters, children) have:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Heartburn <p>Are there any other health problems in your family?</p> <p>_____</p> <p>_____</p>	<p>CC</p> <p>HPI</p> <p style="background-color: #333; color: white; text-align: center; padding: 5px;">PAST FAMILY SOCIAL</p> <p>Past Med Hx</p> <p>Past Surg Hx</p> <p>Family Hx</p>

PATIENT

CLINICIAN

Marital Status S M W D | _____
 With whom do you live? _____
 What is your occupation? _____
 What are your leisure activities? _____

Social Hx

What is your education level? _____

Tell us about your risk of lung disease.

Risk Factors

Please check if you have:

- Worked around toxic chemicals or substances
- Asthma
- Ever smoked
- Lived 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
 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? _____
 For how many years? _____
 If you no longer smoke, when did you quit? _____
 How much alcohol do you drink? _____
 Do you use any recreational drugs?
 Yes No
 List: _____

Allergies

Are you allergic to any medications?
 Yes No

List medications to which you are allergic & reactions:
 1 _____
 2 _____
 3 _____
 4 _____
 5 _____

Do you have hay fever?
 Yes No
 What kind of symptoms do you experience:

Vaccinations

Have you had the following vaccinations?
 Influenza ("Flu Shot") Annually
 Pneumococcal ("Pneumonia") Vaccine

PATIENT

CLINICIAN

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medicine that you've recently stopped taking:

Medicines

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____
- 9 _____
- 10 _____
- 11 _____
- 12 _____
- 13 _____
- 14 _____
- 15 _____
- 16 _____
- 17 _____
- 18 _____
- 19 _____
- 20 _____
- 21 _____
- 22 _____
- 23 _____
- 24 _____
- 25 _____

Please circle any symptom you have, so we can find out more about it:

REVIEW OF SYMPTOMS

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	HEENT
Hearing problems; buzzing or ringing in ears	
Allergies; hay fever	
Sinus problems	
Blood pressure or heart problems	Cardiac
Asthma; tuberculosis	Pulmonary
Stomach problems; heartburn; indigestion; change in bowel habits	Digestive
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems: Frequency; infections; stones; bladder	Urinary
Men: Prostate problems; night-time urination	
Women: Abnormal menstrual periods; could you be pregnant?	
Joint pains swelling or redness; arthritis; back pain	Musculoskeletal
Muscle aches or tenderness; gout	
Rash, itching or other skin problems	Dermatological
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam	Female Reproductive
Paralysis (even temporary); stroke; numbness; loss of balance	Neurological
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	Psychiatric
Suicide attempts	
Thyroid disorder; diabetes; excess thirst; hunger or urination	Endocrinology
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	Hematological

Physical Exam

General Appearance _____ Today's Wt _____ Last Wt _____ Ht _____
 Pulse _____ BP: Sitting (Rt) _____ (Lt) _____ Standing (Rt) _____ (Lt) _____
 Respirations _____ Supine (Rt) _____ (Lt) _____ Pulse Oximetry _____ (_____) _____

All elements of Organ System are examined Normal

Use only if dictated

N=Normal A=Abnormal D=Deferred

Description of Abnorma

1) **NOSE** Mucosa _____ Turb _____ Septum _____ Sinuses _____

2) **MOUTH** Mucosa _____ Teeth _____ Gums _____
 Posterior Pharynx _____ Palate _____
 Hard _____ Soft _____ Tongue _____
 Tonsils _____

3) **NECK** Appearance _____ Masses _____ Symmetry _____
 Trachea Position _____ Crepitus _____
 Thyroid _____ JVD _____

4) **RESP** Inspect _____ Symmetry _____ Effort _____
 Percussion _____ Palpation _____ Ausc _____

5) **HEART** Apex _____ Heave _____
 Thrill _____ Sounds _____ Murmur _____ Rub _____

6) **ABDOMEN** Masses/Tenderness _____ Liver _____ Spleen _____
 Bowel Sounds _____

7) **LYMPH** Neck _____ Axillae _____ Groin _____
 Other (Specify) _____

8) **MUSCULOSKELETAL** Gait _____ Station _____ Strength _____
 Tone _____ Atrophy _____ Abnormal _____
 Movement _____

9) **EXTREMETIES** Varicosities _____ Edema _____ Pulses _____
 Temp _____ Tenderness _____ Digits _____
 Nails _____

10) **SKIN** _____ (Describe scars, rashes, etc.)

11) **NEUROPHYCH** Oriented _____ Mood _____

Notes:

New Patient

99201
 99202
 99203
 99204/
 99205

1-5 Bullet Points
 6-11 Bullet Points
 12-17 Bullent Points
 All Items with Gray Border and 1 Item in
 each Non-Gray Border Box

Office/Hospital Consult

99241/99251
 99242/99252
 99243/99253
 99244/99254
 99245/99255

Medical Decision Making

DATA REVIEWED:

- Lab (Date)
 - HGB _____
 - Lytes _____
 - Other (Specify) _____
- Pulmonary Function Studies - Specify Date: _____
- CXR (Date) _____
- Bronchoscopy (Date) _____
- Other (List/Date) _____

X-Rays (Date)

- _____ Chest
- _____ CT Chest
- _____ MRI
- _____ Other (List type)
- _____ Other (List type)
- _____ Other (List type)

Physician Interpretation:

IMPRESSION:

PLAN:

- F/U _____
- PFT/Spirometry
- Sleep Study/CPAP
- Allergy Skin Testing
- V/Q Scan
- Chest X-ray
- CT Scan/HRCT
- Nocturnal Pulse Oximetry
- Bronchoscopy
- Lab
 - Lytes ABG's
 - Chem PT
 - Pre-op Lipids
- Pulmonary Risk Reduction
- Other _____
- CPEx
 - Six Min. Walk
 - Full Stress Test
- Echo
- Ultrasound
- Thoracentesis
- Bone Density Study
- Smoking Cessation
- ABI ___unilateral___bilateral
- Venous Duplex Scan ___unilateral___

Physician Signature

Requesting/Primary Physician:

I don't know the answer to one
U.

[REDACTED]

HISTORY

