

SOUTHEASTERN LUNG CARE

**ATTENTION NEW PATIENTS – PLEASE BRING A LIST OF YOUR MEDICATIONS WITH YOU TO YOUR APPOINTMENT**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Place of birth: \_\_\_\_\_ Highest grade completed: \_\_\_\_\_ Religion: \_\_\_\_\_

Marital status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Domestic partnership \_\_\_ Widowed

Occupation: \_\_\_ Working (Current occupation \_\_\_\_\_) \_\_\_ Student \_\_\_ Homemaker  
\_\_\_ Retired (Former occupation \_\_\_\_\_) \_\_\_ Disabled \_\_\_ Unemployed

**PAST MEDICAL HISTORY (check if appropriate):**

- |  |   |   |
|--|---|---|
| Yourself<br><input type="checkbox"/> Alpha-1 Antitrypsin deficiency<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood clots<br><input type="checkbox"/> Blood transfusion<br><input type="checkbox"/> CAD<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> CHF<br><input type="checkbox"/> Chronic bronchitis<br><input type="checkbox"/> COPD<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema | Yourself<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hiatal Hernia<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> HIV infection<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Lung disease<br><input type="checkbox"/> Lung mass<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Narcolepsy<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Other heart disease | Yourself<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Renal disorders<br><input type="checkbox"/> Restless Legs Syndrome<br><input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Sarcoidosis<br><input type="checkbox"/> Scleroderma<br><input type="checkbox"/> Seizure disorder<br><input type="checkbox"/> Sleep apnea<br><input type="checkbox"/> Snoring<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid disease<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers |
|--|---|---|

**FAMILY MEDICAL HISTORY (check if appropriate):**

- |   |  |
|---|--|
| Family member<br><input type="checkbox"/> Alpha-1 Antitrypsin deficiency<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood clots<br><input type="checkbox"/> CAD<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Heart attack | Family member<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Lung disease<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Renal disorders<br><input type="checkbox"/> Sarcoidosis<br><input type="checkbox"/> Sleep apnea<br><input type="checkbox"/> Stroke |
|---|--|

**LIST ALL OPERATIONS:**

- |    | <u>Date</u> | <u>Hospital</u> | <u>Procedure</u> |
|----|-------------|-----------------|------------------|
| 1. | _____       | _____           | _____            |
| 2. | _____       | _____           | _____            |
| 3. | _____       | _____           | _____            |

**HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST TWO YEARS?**

- |    | <u>Date</u> | <u>Reason</u> |
|----|-------------|---------------|
| 1. | _____       | _____         |
| 2. | _____       | _____         |
| 3. | _____       | _____         |

**LIST ALLERGIES:** \_\_\_\_\_

# SOUTHEASTERN LUNG CARE

**CURRENT HABITS:** \_\_\_\_ I **currently** smoke \_\_\_\_ packs per day for \_\_\_\_ years      \_\_\_\_ I **never** smoked  
\_\_\_\_ I **formerly** smoked \_\_\_\_ packs per day for \_\_\_\_ years; I quit smoking (when?) \_\_\_\_\_

**ALCOHOL CONSUMPTION:** \_\_\_\_\_ # of drinks per (circle one) day/week/month

**REVIEW OF SYSTEMS – (check symptoms you experienced):**

**CONSTITUTIONAL:**

- change in weight
- fever/chills
- night sweats

**RESPIRATORY:**

- shortness of breath
- cough
- coughing up blood
- wheezing

**CARDIAC:**

- chest pain/discomfort
- shortness of breath on reclining
- racing/irregular heartbeat
- blackout spells
- ankle swelling
- aching legs when walking

**ALLERGIC:**

- allergies to dust, animals, pollen
- seasonal hay fever

**SLEEP:**

- excessive sleepiness
- insomnia
- loud snoring
- breath stops in sleep
- leg pain at night

**EYES, EARS, NOSE, THROAT:**

- difficulty hearing
- frequent bloody nose
- sinus infection
- hoarseness

**GASTROINTESTINAL:**

- nausea/vomiting
- vomiting blood
- difficulty swallowing
- heartburn

**GENITOURINARY:**

- burning/painful urination
- nighttime urination

**NEUROLOGIC:**

- frequent headache
- numbness/tingling
- weakness
- seizures

**SKIN:**

- itching
- rash

**ENDOCRINE:**

- heat/cold intolerance
- excessive thirst

**HEMATOLOGIC:**

- anemia
- enlarged lymph nodes
- excessive bleeding/bruising
- blood clots

**MUSCULOSKELETAL:**

- joint stiffness
- joint swelling

**PSYCHIATRIC:**

- psychiatric illness
- drug/alcohol addiction

I have reviewed the past medical history, medications, social history, family history, and review of systems during this visit.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Clinical staff member

\_\_\_\_\_  
Date