

SOUTHEASTERN LUNG CARE

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

Name: _____ Date of birth: _____ Date: _____

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

FAMILY MEDICAL HISTORY (check if appropriate):

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

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

SOUTHEASTERN LUNG CARE

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