**Pulmonary Follow Up** Pulmonary Associates (Template Sx.Pulm.Universal.FU, ver 1.1)

**Name:** _____ **DOB:** _____ **Date:** _____

**List any problems or new concerns:**

_____

- **Since your last visit, are your respiratory problems:** ☐ Better ☐ Worse ☐ Same
- **Since your last visit, have you been treated for respiratory problems?**

  ☐ No ☐ Yes, in ER ☐ Yes, in hospital ☐ Yes, in doctor's office ☐ Yes, over phone
- **Have you been hospitalized since our list visit?**

  ☐No ☐ Yes. Hospital name: _____ Date: _____
- **Do you use oxygen?**

  ☐ No ☐ Yes. Setting is _____ liters. Used:☐ night day ☐ as needed ☐ 24/7
- **Do you smoke?**

  ☐ Never ☐ No, I quit. ☐ Yes. I smoke _____ packs per day.
- **What is your pneumonia vaccine status?**

  ☐ Never ☐ Within last 5 years ☐ Within last 10 years ☐ More than10 years
- **What is your Flu vaccination status?**

  ☐ Never ☐ This year ☐ Last year ☐ More than 2 years
- **If you have a rescue inhaler, how often do you use it?**

  ☐ None recently ☐ 1 -3 per week ☐ 4-6 per week ☐ daily ☐ more than twice daily
- **Have you had a Chest X-Ray or CT Scan (of Chest} since our last visit?**

  ☐ No ☐ Yes, at _____

**Please check symptoms that currently apply:**

☐ Cough ☐ Sputum production ☐ Cough up blood ☐ Chest pain ☐ Fever

☐ Shortness of breath ☐ Chest tightness ☐ Wheezing ☐ Sinus problems

☐ Other respiratory symptoms: _____

**Please note any new medicines or medicine changes since our last visit:**

_____

## CONTINUES ON BACK

**OFFICE USE ONLY:**

MR#: _____

HPI:

PE:

Gen-

MP-1 2 3 4

Den· Y N

Neck-

CV- M G

Chest-

Abd-

Ext-

Ass:

Plan:

## **Review of Systems** Pulmonary Associates (Template Sx.Pulm.ROS)

Please check any of the following symptoms which apply to you:

- **CONSTITUTIONAL**

  ☐ Fever ☐ Chills ☐ Sweats ☐ Weight Gain ☐ Weight loss

- **EYES**

  ☐ Eye pain ☐ Double Vision ☐ Blurred vision

- **HENT**

  ☐ Headaches ☐ Post nasal drip ☐ Nasal Congestion ☐ Nasal discharge

- **CARDIOVASCULAR**

  ☐ Chest pain ☐ Irregular heart beat ☐ Swelling ☐ Passing out

- **RESPIRATORY**

  ☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Sputum production

  ☐ Hoarseness ☐ Coughing up blood ☐ TB Exposure ☐ Chest wall pain

- **GASTROINTESTINAL**

  ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Reflux

  ☐ Blood in stools ☐ Jaundice ☐ Abdominal pain

- **GENITOURINARY**

  ☐ Frequent urination ☐ Night time urination ☐ Blood in urine

- **SKIN**

  ☐ Rash ☐ Itching ☐ Skin lesion

- **NEUROLOGIC**

  ☐ Weakness ☐ Seizures ☐ Altered mental status

- **MUSKULOSKELETAL**

  ☐ Joint pain ☐ Back Pain ☐ Joint swelling

- **SLEEP**

  ☐ Snoring ☐ Insomnia ☐ Daytime sleepiness

- **PSYCHIATRIC**

  ☐ Anxiety ☐ Depression ☐ Psychosis

- **ALLERGIC-IMMUNOLOGIC**

  ☐ Sinus allergies ☐ Eczema ☐ Food allergies