Pulmonary History (Template Sx.Pulm.New, ver1.1)

Name: ________________________________ **DOB:** ______________ **Date:** ________________

Referring Physician: ___________________________ **Primary Physician:** ________________________

Occupation (include pre-retirement) ____

What symptoms or concerns prompted this evaluation? ______________________________________

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Please clarify your smoking history:

☐ I have never smoked ☐ I quit smoking (see bubble sheet) ☐ Current smoker (see bubble sheet)

☐ Second hand smoke exposure (specify) ____

Please check any pulmonary symptoms that apply:

☐ cough ☐ shortness of breath ☐ wheezing ☐ coughing up blood ☐ chest pain

☐ sputum production ☐ breathing problems during sleep ☐ chest wall pain

☐ chest tightness ☐ Other ____

Have you ever been diagnosed with any of the following?

☐ abnormal CXR or CT of chest ☐ COPD ☐ emphysema ☐ asthma ☐ pulmonary fibrosis

☐ sarcoid ☐ bronchiectasis ☐ lung cancer ☐ asbestosis ☐ pulmonary hypertension

☐ low oxygen levels ☐ lung surgery ☐ recurrent bronchitis ☐ TB ☐ sleep apnea ☐ HIV

☐ other lung problems (specify) ____

How long have you had pulmonary problems? _____________________________________

How would you describe your symptoms? ☐ mild ☐ moderate ☐ severe

Are your pulmonary symptoms improved by any of the following?

☐ inhalers or nebulized medicine (specify) ___________________________________

☐ steroids ☐ antibiotics ☐ other medication (specify) __________________________

☐ rest ☐ Other ____

Are your pulmonary symptoms aggravated by any of the following?

☐smoke ☐strong odors or smells ☐changes in weather ☐ changes in season

☐ physical activity ☐ exposures at work ☐ eating/drinking ☐ fluid retention

☐ medication (specify) ____

☐ Other ____

Have you ever been exposed to any of the following?

☐ asbestos (specify exposure and duration) __________________________________

☐ coal dust ☐ sand blasting or silica ☐ cotton dusts ☐ exotic pets (esp. birds)

☐ chicken house ☐ grain dust ☐ TB ☐ Beryllium ☐ brake mechanic ☐ pipe fitting

☐ Other heavy dusts, chemicals, fumes, or gases (specify) _______________________

Have you ever taken any of the following medicines?

☐ ACE Inhibitors for BP (e.g. Lisinopril, Enalapril, *pril) ☐ Amiodarone for heart rhythm

☐ Methotrexate ☐ Nitrofurantoin/Macrodantin/Macrobid for frequent UTI ☐ Bleomycin

☐ Chemotherapy ☐ Gold ☐ Aspirin ☐ NSAIDS (e.g. Ibuprofen, Motrin, Aleve, etc.)

☐ Beta blockers

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

Medications

Please list all medication allergies:

Please provide a complete list of medications with dosing information:

Medication Name	Dose	Frequency