PULMONARY CARE OF CENTRAL FLORIDA, P.A.

Date: ____ / ____ / ____

Patient Name ______________________ Age ________ DOB: _____ /_____ /______

Family Physician ______________________ Telephone Number ______________

Referring Physician ______________________ Telephone Number ______________

Pharmacy: ______________ Phone: ______________ Fax: ______________

MEDICAL HISTORY

1. What is your reason for visiting the doctor today? ______________________________
   ____
2. When did you first notice this problem? ______________________________
3. What do you expect to gain from today's visit? ______________________________
   ____
4. Do you have any of the following? *(Please* check *'yes' or 'no'.* ***If yes, please explain.)***

a)	Shortness of breath	☐ No ☐ Yes	______________
b)	Wheezing	☐ No ☐ Yes	______________
c)	Hay Fever (Allergies)	☐ No ☐ Yes	______________
d)	Cough	☐ No ☐ Yes	______________
e)	Cough up phlegm	☐ No ☐ Yes	______________
f)	Coughing up blood	☐ No ☐ Yes	______________
g)	Fevers	☐ No ☐ Yes	______________
h)	Recent weight change	☐ No ☐ Yes	______________
i)	Sleeping disorder	☐ No ☐ Yes	______________
j)	Difficulty swallowing	☐ No ☐ Yes	______________
k)	Chest Pain	☐ No ☐ Yes	______________
l)	Chest tightness	☐ No ☐ Yes	______________

5. Do you smoke? ☐ Yes ☐ No   How long? (years) _______   Packs per day? ________
6. Have you ever smoked? ☐ Yes ☐ No   How long? (years) _____   When did you quit? _____

   If yes, how much did you smoke? ______________________

7. Have you ever been given:

	Date	Location / Where
a) Pneumonia vaccine	______________	______________________
b) Flu vaccine	______________	______________________

Patient Name: ___________________________________

8. Have you ever been diagnosed with any of the following? *(Please* check *'yes' or 'no'.)*

Asthma	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes
Allergies	☐ No	☐ Yes	Blood Disorders	☐ No	☐ Yes
Sinusitis	☐ No	☐ Yes	Pulmonary Hypertension	☐ No	☐ Yes
Sleep Apnea	☐ No	☐ Yes	Emphysema	☐ No	☐ Yes
Lung Cancer	☐ No	☐ Yes	Pleurisy	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Pneumothorax	☐ No	☐ Yes
Pulmonary Emboli	☐ No	☐ Yes	Pulmonary Fibrosis	☐ No	☐ Yes
Bronchiectasis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Colitis	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Hypertension	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes
Seizures	☐ No	☐ Yes	Irregular Heart Rate	☐ No	☐ Yes
Thyroid Problems	☐ No	☐ Yes	Stomach Ulcers	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Other	______________________		Liver Disease	☐ No	☐ Yes

If you answered 'yes' above, please explain. ____

____

____

9. Please list all previous surgeries and hospitalizations:

Date	Surgery Type/ Reason for Hospitalization	Location	Surgeon/Attending Physician

10: List any other medical illnesses:

____

____

____

____

____

Patient Name: ___________________________________

REVIEW OF SYSTEMS: *(Please check 'yes' or 'no'.)*

Constitutional:

Fatigue	☐ No ☐ Yes
Fever	☐ No ☐ Yes
Night sweats	☐ No ☐ Yes
Weight loss	☐ No ☐ Yes
Weight gain	☐ No ☐ Yes

Pulmonary:

Shortness of breath	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes
Cough	☐ No ☐ Yes

Ear, Nose, and Throat:

Sore throat	☐ No ☐ Yes
Ear ringing	☐ No ☐ Yes
Decreased hearing	☐ No ☐ Yes
Dental problems	☐ No ☐ Yes
Oral lesions	☐ No ☐ Yes
Difficulty swallowing	☐ No ☐ Yes
Hoarseness	☐ No ☐ Yes

Renal:

Pain/Burning urination	☐ No ☐ Yes
Frequent urination	☐ No ☐ Yes
Nocturnal frequency	☐ No ☐ Yes

Skin & Breast:

Skin lesions	☐ No ☐ Yes
Rashes	☐ No ☐ Yes
Breast masses	☐ No ☐ Yes
Discharge	☐ No ☐ Yes

Psychiatric:

Depression	☐ No ☐ Yes
Anxiety	☐ No ☐ Yes

Sleep-Related Symptoms:

Snoring	☐ No ☐ Yes
Sleepy during daytime	☐ No ☐ Yes
Restless sleep	☐ No ☐ Yes
Difficulty sleeping	☐ No ☐ Yes
Daytime fatigue/tired	☐ No ☐ Yes

Eyes:

Need for glasses	☐ No ☐ Yes
Blurred vision	☐ No ☐ Yes
Double vision	☐ No ☐ Yes
Loss of vision	☐ No ☐ Yes

Cardiac:

Chest pain	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Leg swelling	☐ No ☐ Yes

Gastrointestinal:

Heartburn	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Blood in stool	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Loss of appetite	☐ No ☐ Yes
Reflux / GERD	☐ No ☐ Yes

Musculoskeletal:

Back problems	☐ No ☐ Yes
Joint swelling	☐ No ☐ Yes
Joint pain	☐ No ☐ Yes

Neurological:

Dizziness	☐ No ☐ Yes
Lethargy	☐ No ☐ Yes
Passing out	☐ No ☐ Yes
Weakness	☐ No ☐ Yes
Difficulty speaking	☐ No ☐ Yes
Seizures	☐ No ☐ Yes

Endocrine

Enlarged thyroid	☐ No ☐ Yes
Thyroid nodules	☐ No ☐ Yes
Thirst	☐ No ☐ Yes
Heat/cold intolerance	☐ No ☐ Yes

Patient Name: ___________________________________

SOCIAL HISTORY

1. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

2. Number of Children ______

3. Alcohol Intake ☐ Yes ☐ No How much? _____________ How often? _____________

4. Recreational Drugs ☐ Yes ☐ No

5. Dwelling: Carpet ☐ Yes ☐ No
Central A/C ☐ Yes ☐ No
Pets ☐ Yes ☐ No What kind? _______________ How many? _____________

EXPOSURE HISTORY

1. Where were you born? ____

2. Where were you raised? ____

3. Occupation – Present/Past ____

4. Hobbies: ____

5. Have you ever worked with or around the following (if so, please explain):

a. Indoor smoking environment ____
b. Asbestos _________________________ e. Mining _______________________________
c. Welding __________________________ f. Animals _______________________________
d. Soldering _________________________ g. Inhalants _____________________________

FAMILY HISTORY

Have any members of your family ever had (please check):

Disease	Relationship
1. ☐ Diabetes	________________________________
2. ☐ Lung Cancer	________________________________
3. ☐ Cancer	________________________________
4. ☐ High Blood Pressure	________________________________
5. ☐ Emphysema	________________________________
6. ☐ Asthma	________________________________
7. ☐ Kidney Disease	________________________________
8. ☐ Sleep Apnea	________________________________

Patient Name: ___________________________________

MEDICATION INFORMATION

1. List all medication allergies and type of reaction: ____

____

____

2. List all current medications:

Medication	Dosage	Frequency	Prescriber
*Please use the back of this form if needed			

Patient Name: ___________________________________

Medications continued:

Medication	Dosage	Frequency	Prescriber