Pulmonary & Critical Care Medicine Associates

Expertise, Compassion, Results

Address: 50 N 12th Street, Lemoyne, PA 17043
Phone: 717-234-2561

PATIENT INFORMATION

Name: ____ Birth Date: ______________________________

Address: ___________________________________ City: ____________________ State: ________ Zip: __________

Gender: Male Female (circle one) Marital Status: Married Divorced Widowed Single (circle one)

Home Phone: ____________________ Work Phone: __________________ Cell Phone: _____________________

Referring Physician: ______________________________ Family Physician: ____________________________

Emergency Contact: ______________________________________ Relationship: ___________________________

Emergency Contact Phone: __________________________________

NEW PULMONARY PATIENT QUESTIONNAIRE

What brings you to our office today? ____

How long have you had this problem? ____

Have you seen a lung doctor in the past? ______ If yes, who? ___________________________ when? _____________

PAST MEDICAL HISTORY

Do you have any of the following lung problems?

- ❑ COPD (Emphysema, chronic bronchitis)
- ❑ Asthma
- ❑ Pulmonary fibrosis
- ❑ Lung cancer
- ❑ Pulmonary embolism
- ❑ Cystic fibrosis
- ❑ Pleural effusion
- ❑ Tuberculosis
- ❑ Pulmonary hypertension
- ❑ Sarcoidosis
- ❑ Asbestosis
- ❑ Pneumothorax
- ❑ Other ____

Do you have any of the following health problems?

- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Sleep apnea
- ❑ Congestive heart failure
- ❑ Coronary artery disease
- ❑ Atrial fibrillation
- ❑ Acid Reflux
- ❑ Allergic rhinitis
- ❑ DVT (blood clots in legs)
- ❑ Rheumatoid arthritis
- ❑ Hypothyroidism
- ❑ Lupus
- ❑ Kidney disease
- ❑ Other medical conditions ______________________

____

Please list any major hospitalizations if any.

____

____

Patient Name: ____ Date of Birth: ______________________

Please check if you had any of these tests done, please list where and when they were done.

❑ PFT (Breathing tests) ____

❑ Chest X-ray ____

❑ CT scan of chest ____

Do you have any of the following in your home? (Check if applicable):

❑ Oxygen ❑ Nebulizer machine ❑ CPAP/BiPAP

If yes, who is your medical supplier (DME)? ____

Have you received any of the following vaccine?

Pneumonia vaccine ❑ Yes ❑ No Date: _______________ ***Flu vaccine*** ❑ Yes ❑ No Date: _______________

PAST SURGICAL HISTORY

❑ Lung surgery ❑ CABG (bypass surgery) ❑ Heart valve replacement

❑ Cholecystectomy (gall bladder removal) ❑ Pacemaker/ICD placement ❑ Other surgeries

____

FAMILY HISTORY

Check if applicable, and which relative has the condition:

Condition	Yes	Who	Condition	Yes	Who
Lung cancer	_____	______________________	High blood pressure	_____	______________________
Emphysema	_____	______________________	Heart disease	_____	______________________
Sleep apnea	_____	______________________	Stroke	_____	______________________

SOCIAL HISTORY

Do you smoke?______________Have you ever smoked?_______If yes, how many packs per day?____________________

How many years have you been smoking?____________ If no longer smoking, when did you quit? ____________________

How many years did you smoke before you quit?_______Does anyone in your house smoke?_________________________

Do you drink alcohol?_________ If yes, how often?____

Do you use street drugs?_____________ What is/was your occupation?____

Check if you've had any prolonged exposure to the following:

❑ Asbestos ❑ Dust ❑ Fumes ❑ Tuberculosis ❑ Other: _______________________________________

Please list any pets/animals you have/had: ____

____

ALLERGIES

❑ Medications ❑ None ❑ Yes ____

Patient Name: ____ Date of Birth: ______________________

REVIEW OF SYSTEMS

General	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue	☐ Night sweats
Sleep	☐ Excessive sleepiness	☐ Snoring	☐ Non-refreshing sleep	☐ Sleep walking	☐ Insomnia
ENT	☐ Post nasal drip	☐ Sinus congestion	☐ Nasal polyps	☐ Hoarseness	☐ Ulcers in mouth
Respiratory	☐ Shortness of breath	☐ Chronic cough	☐ Coughing up blood	☐ Wheezing	☐ Pleurisy
Cardiovascular	☐ Chest pain	☐ Leg swelling	☐ Palpitation	☐ Passing out	☐ Irregular heartbeat
Gastrointestinal	☐ Swallowing difficulty	☐ Acid reflux	☐ Abdominal pain	☐ Vomiting	☐ Blood in stool
Genitourinary	☐ Frequent urination	☐ Incontinence	☐ Hesitancy	☐ Urgency	☐ Blood in urine
Musculoskeletal	☐ Joint stiffness	☐ Joint pain	☐ Back pain	☐ Muscle weakness	☐ Muscle pain
Hematology	☐ Lymph gland swelling	☐ Blood clots	☐ Easy bruising	☐ Cancer	☐ Anemia
Nervous system	☐ Weakness	☐ Tremors	☐ Headache	☐ Dizziness	☐ Restless legs
Endocrinology	☐ Loss of appetite	☐ Cold intolerance	☐ Heat intolerance	☐ Goiter	☐ Excessive thirst
Skin	☐ Jaundice	☐ Eczema	☐ Itching	☐ Hair loss	☐ Rash

MEDICATIONS

Please write or provide a list of ALL medications you are currently taking, including prescription, over-the-counter, herbal supplements and any inhalers.

	MEDICATION NAME	DOSE	FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

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