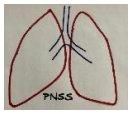

Pulmonary N Sleep Specialists PC

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Board Certified in Pulmonary Diseases, Critical Care, and Sleep Medicine
Holly Wuest, ACNP-BC Lindsey Reames, CNP

PULMONARY & MEDICAL HISTORY

Name _____ Date of Birth _____

Reason for today's visit _____ Date of Visit _____

Family Physician _____ Referring Physician _____

Name of other physician to send reports to _____

Were you recently hospitalized? _____ If yes, dates of hospital stay_____

Reason for hospitalization_____ Are you feeling better now?_____

Reason for follow-up with us_____

Any problems since hospital discharge?_____ If yes, explain_____

PULMONARY HISTORY

	YES	NO
1. Do you have a cough? If so, for how long?		
2. Do you cough up yellow/green phlegm?		
3. Are you coughing up any blood or blood-tinged phlegm?		
4. Are you short of breath? If so, for how long?		
5. Are you short of breath at rest?		
6. Are you short of breath with exertion?		
7. Is your shortness of breath becoming worse over time?		
8. Do you wake up in the middle of the night with difficulty breathing?		
9. Do you get chest pain with breathing difficulty?		
10. Do you wheeze at times?		
11. Do your ankles/feet develop swelling?		
12. Do you suffer from a runny nose or sinus drainage?		
13. Do you suffer from recurrent sore throats?		
14. Do you sleep propped up in bed or sleep in a recliner?		

Name _____ Date of Birth _____

PAST MEDICAL HISTORY

Have you ever had or been diagnosed with:

	YES	NO	YEAR		YES	NO	YEAR
Asthma, emphysema, bronchitis				Pneumonia or pleurisy			
Collapsed lung				Tuberculosis or positive TB test			
Spot on lung, lung cancer				Coughing up blood			
Lung surgery				Black lung			
Blood clot in lungs/legs				Steroid therapy			
Other cancer				Chemotherapy			
Allergies, hay fever				Radiation treatment			
Heart attack, murmur				Congestive heart failure			
Irregular heart beat				Heart surgery			
High blood pressure				Diabetes			
Goiter or thyroid problem				Blood disease, anemia			
Stroke/seizure				Nervous disorder or depression			
Peptic ulcer, hiatal hernia				Colitis, liver problem			
Prostate problem				Sleep apnea			
Tonsillectomy				Sinus surgery			
Other surgeries				Blood transfusion			

Any illness or disease not included above: _____
_____

Any surgeries not included above: _____

Have you ever had a serious injury or accident? _____

Last flu vaccine date (month/year)_____ Last pneumonia vaccine (month/year)_____

ALLERGIES:

Do you have any allergies to medications, food, insect stings? NO YES
If yes, please list allergies and reactions :

Medicine/Allergy	Type of Reaction

Name _____ Date of Birth _____

CURRENT OR PAST USE OF ANY OF THESE MEDICATION / DEVICES:

	YES	NO	DETAILS
OXYGEN			
CPAP / BIPAP			
NEBULIZER			
INHALERS			

CURRENT MEDICATIONS (PLEASE LIST YOUR INHALERS/NEBULIZERS):

NAME OF MEDICINE DOSE SCHEDULE / HOW OFTEN

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name _____ Date of Birth _____

REVIEW OF SYSTEMS :

Are you currently having any of the following:

	YES	NO
1. Weight change of more than 5 pounds in the last 6 months?		
2. Recent unexplained fever, chills or night sweats?		
3. Do you feel fatigued or tired?		
4. Do you have dizziness, lightheadedness, vertigo or fainting spells?		
5. Do you have headaches?		
6. Do you have any vision problems other than prescription glasses or contact lenses?		
7. Do you have any problems with hearing: hearing loss, ringing, earache, itching?		
8. Do you have any nosebleeds or difficulty breathing through your nose?		
9. Do you get heart palpitations or fluttering (racing of heart or skip beats)?		
10. Do you have any heart troubles including heart murmurs or chest pains?		
11. Do you have any trouble swallowing?		
12. Do you get heartburn or sour taste in your mouth?		
13. Has there been any recent change in your appetite?		
14. Do you get pain in your legs when you walk any distance or at night?		
15. Do you have nausea, vomiting, diarrhea, constipation or pain in stomach?		
16. Do you have intolerance to hot or cold surroundings?		
17. Do you have excessive thirst or excessive urination?		
18. Do your joints swell, hurt or feel stiff?		
19. Do you tremble or shake abnormally?		
20. Do you get easily irritated?		
21. Do you have trouble falling asleep or staying asleep?		
22. Do you snore?		
23. Do you fall asleep while driving, watching TV or reading?		
24. Do you use an over-the-counter or prescription sleeping pill?		
25. Do you have bleeding tendency, anemia, easy bruising?		
26. Do you have any urine disturbance?		
27. Do you have rectal or urinary bleeding?		
28. Females: Do you have vaginal bleeding? (other than regular menstrual cycle)		

Females: Are you currently pregnant or is there a chance you could be pregnant? NO YES

Name _____ Date of Birth _____

FAMILY HISTORY (blood relatives only)

Relative		Present Age or Age at Death	Present Health or Cause of Death
Father	Living? Yes No		
Mother	Living? Yes No		
Brothers	Number Living? Number deceased?		
Sisters	Number living: Number deceased?		
Children	Number living: Number deceased?		

HAVE ANY OF YOUR BLOOD RELATIVES HAD (IF YES, INDICATE RELATIONSHIP)

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Asthma				Emphysema			
Lung Cancer				Diabetes			
High blood pressure				Heart Disease			
Tuberculosis				Arthritis			
Lupus				Cancer			
Stroke				Allergies			
Seizures							

SOCIAL HISTORY

Do you now or have you ever smoked cigarettes, cigar or pipe? NO YES

Now? NO YES If yes, how many packs per day? _____ For how long? _____

In the past? NO YES If yes, when did you quit? _____

Does your spouse or anyone living in your house smoke? NO YES
Do you drink alcohol on a regular basis? NO YES
If yes, how much and how often? _____

What pets do you have at home?_____
Do you use any illicit drugs? NO YES
Have you been exposed to asbestos, beryllium, coal mine dust or other chemicals at work or at homes? NO YES
Any recent travel? NO YES
Do you exercise on a regular basis? NO YES

_____
Reviewing Provider's Signature