New Patient Medical History Form

Name: ______________________________ Date of Birth: ____________________
Date: __________ Referring Provider: ____________________ Primary Care Provider: ______________

Why are you seeing a pulmonary (lung) provider? ______________________________
____
____

Have you recently been hospitalized: Yes **When:** _______month/year **Where:**____________________
Have you recently been in Urgent Care: Yes **When:** _______month/year **Where:** ____________________

Have you recently had any of the following:

☐Chest X Ray **When:** ____________month/year **Where:** ____________________
☐Chest CT (cat scan) **When:** ____________month/year **Where:** ____________________
☐Echocardiogram **When:** ____________month/year **Where:** ____________________

Have you had exposure to chemicals: Yes No **Type:** ______________________________
Have you recently traveled outside of the country: Yes No **Where:** ____________________

Have you had Flu Vaccine(s): Yes No I do not wish to have vaccines
Please list the last : ____________month/year

Have you had Pneumonia Vaccine(s): Yes No I do not wish to have vaccines
Which one and when: Prevnar 13 __________date, Pneumovax __________date

REVIEW OF SYMPTOMS

Please check any symptoms you are CURRENTLY experiencing below:

GENERAL

- ☐ **NONE**
- ☐ Fatigue (easily tired)
- ☐ Malaise (generally unwell)
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain

ENT

- ☐ **NONE**
- ☐ Earache
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Post Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat

RESPIRATORY

- ☐ **NONE**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Pain with Breathing
- ☐ Wheezing
- ☐ Known TB Exposure

CARDIOVASCULAR

- ☐ **NONE**
- ☐ Chest Pain
- ☐ Claudication (leg pain with activity)
- ☐ Edema (lower leg swelling)
- ☐ Palpitations
- ☐ Orthopnea (shortness of breath when lying down)

GASTROINTESTINAL

- ☐ **NONE**
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY

- ☐ **NONE**
- ☐ Increase in Urination
- ☐ Urination During the Night

PSYCHOLOGICAL

- ☐ **NONE**
- ☐ Anxiety
- ☐ Depression

DERMATOLOGIC

- ☐ **NONE**
- ☐ Hives
- ☐ Rash
- ☐ Itching
- ☐ Skin Lesions

NEUROLOGICAL

- ☐ **NONE**
- ☐ Dizziness
- ☐ Numbness in Hands/Feet
- ☐ Weakness in One/Both Arms/Legs
- ☐ Abnormal Gait (unusual walking)
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors

MUSCULOSKELETAL

- ☐ **NONE**
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness

HEMATOLOGIC/LYMPHATIC

- ☐ **NONE**
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Lymph nodes/glands

IMMUNOLOGIC

- ☐ **NONE**
- ☐ Seasonal Allergies
- ☐ Contact Allergies
- ☐ Food Allergies
- ☐ Inhalation Allergies

SLEEP

- ☐ **NONE**
- ☐ Insomnia
- ☐ Wake with Gasping/Choking
- ☐ Sleepiness During the Daytime
- ☐ Restless Sleep
- ☐ Snoring

PERSONAL MEDICAL HISTORY

PULMONARY
- ☐ Allergies
- ☐ Alpha 1 Antitrypsin
- ☐ Asbestosis
- ☐ Asthma
- ☐ Recurrent Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Nodule(s)
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Valley Fever (Coccidioidomycosis)

RHEUMATOLOGIC
- ☐ Lupus
- ☐ Rheumatoid Arthritis

CARDIOVASCULAR
- ☐ Anemia
- ☐ Atrial Fibrillation
- ☐ Blood Clots/DVT
- ☐ Chest Pain (Angina)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Elevated Cholesterol
- ☐ High Blood Pressure (HTN)
- ☐ Heart Attack (MI)
- ☐ Murmur/Heart Valve Disease
- ☐ Stroke

GASTROINTESTINAL
- ☐ Acid Reflux (GERD)
- ☐ Hepatitis

GENITOURINARY
- ☐ Kidney Stones
- ☐ Chronic Kidney Disease

NEUROLOGIC/PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Insomnia
- ☐ Restless Leg Syndrome

METABOLIC
- ☐ Diabetes, Type: 1 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis

OTHER
- ☐ Cancer, Type: ____________________
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Immunoglobulin Deficiency

Additional Medical History ____

____

____

____

SURGICAL HISTORY

PULMONARY	YEAR
☐ Bronchoscopy	______
☐ Lobectomy: L R	______
☐ Lung Biopsy	______
☐ Lung Surgery	______
☐ Tonsillectomy	______
☐ Adenoidectomy	______
☐ Tracheostomy	______
☐ Sinus Surgery	______
CARDIOVASCULAR	______
☐ CABG/Open Heart Surgery	______
☐ Cardiac Catheterization	______
☐ Cardiac Stent	______
☐ Pacemaker	______

GASTROINTESTINAL	YEAR
☐ Appendix Removal	______
☐ Gall Bladder Removal	______
☐ Gastric Bypass	______
☐ Hernia Repair	______
GENITOURINARY	______
☐ Dialysis	______
☐ Kidney Stone Removal	______
☐ Kidney Removal	______
MUSKULOSKELETAL	______
☐ Back Surgery	______
☐ Hip Replacement: L R	______
☐ Knee Replacement: L R	______
☐ Neck Surgery	______
☐ Rotator Cuff Repair: L R	______
	______

FEMALE	YEAR
☐ C-Section (Cesarean)	______
☐ Hysterectomy	______
☐ Tubal Ligation	______
MALE	______
☐ Prostate Surgery	______
OTHER	______
☐ Cataract Surgery	______
☐ LASIK	______
☐ Lymph Node Biopsy	______
☐ Mastectomy	______
☐ Thyroidectomy	______

Additional Surgical History ____

____

____

____

FAMILY HISTORY

☐ **No Significant Family History** ☐ **Adopted**

PULMONARY				
Alpha 1 Antitrypsin	☐ Father	☐ Mother	☐ Brother	☐ Sister
Asthma	☐ Father	☐ Mother	☐ Brother	☐ Sister
COPD	☐ Father	☐ Mother	☐ Brother	☐ Sister
Emphysema	☐ Father	☐ Mother	☐ Brother	☐ Sister
Pulmonary Fibrosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Pulmonary Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
Sarcoidosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Sleep Apnea	☐ Father	☐ Mother	☐ Brother	☐ Sister
CANCER				
Breast Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Colon Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Lung Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Other Cancer ________________	☐ Father	☐ Mother	☐ Brother	☐ Sister
CARDIOVASCULAR				
Coronary Artery Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
Venous Thrombosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
RHEUMATOLOGIC				
Rheumatoid Arthritis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Lupus	☐ Father	☐ Mother	☐ Brother	☐ Sister
NEUROLOGICAL				
Alzheimer's	☐ Father	☐ Mother	☐ Brother	☐ Sister
Dementia	☐ Father	☐ Mother	☐ Brother	☐ Sister
ENDOCRINE				
Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister
SOCIAL				
Alcoholism	☐ Father	☐ Mother	☐ Brother	☐ Sister
Drug Abuse	☐ Father	☐ Mother	☐ Brother	☐ Sister

Additional Family History ____

SOCIAL HISTORY

Do you use Tobacco: Yes No Former **Type of Tobacco:** Cigarettes Cigar Pipe Chew Smokeless
Overall Daily Average: __________ pack(s)/pipe/can **Total # of Years Used:** ____________ **Date Quit:** ____________

Do you drink Alcohol: Yes No Former **How Much:** ________ Beers/Glasses/Drinks
Date Quit: __________ **How Often:** Daily Weekly Monthly Yearly

Do you drink Caffeine: Yes No **Type of Caffeine:** Coffee Tea Soda Energy drinks **How Much:** ______ cups/ounces

Do you use Recreational drugs: Yes No Former **Type:** ___________ **Date Quit:** ___________

Do you Exercise: Yes No **Type of Exercise:** ______________ **How Often:** Daily Weekly Monthly

Occupation: ___________________________ **Marital Status:** Single Married Life Partner Divorced Widowed

# of Children: _____ Sons _____ Daughters **Pets:** Yes No **Type:** ________________________

TEXAS LUNG CARE

MEDICATION INFORMATION

NAME: **BIRTHDATE:**

PHARMACY INFORMATION

NAME: **ADDRESS:** **PHONE:**

ALLERGIES

Please List all food and drug allergies and the type of reaction

DRUG	REACTION

MEDICATION LIST

Please list all medications and INHALERS

MEDICATION	DOSAGE	FREQUENCY