STATCARE PULMONARY CONSULTANTS
History and Physical

For Physician Use
Please do not write
in this area

PATIENT NAME: _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ MR# _____

REFERRING DOCTOR: _____PCP DR: _____

Why are you seeing the doctor? _____

What is the main issue you want the doctor to treat today? _____

Name of Pharmacy_____ Telephone _____

PHYSICAL SYMPTOMS: (Please circle all that apply. Write in description if needed)

GENERAL:
Weight gain over past year, how much? _____
Weight loss over past year, how much? _____
YES/NO intentional?
Fever_____ Chills_____ Sweats_____
Poor appetite
Unusual swelling/lumps
Steroid use in the past year
(prednisone, decadron, medrol)
Recent hot tub use
Long distance travel in the past 6 months
Pets at home
Dogs, Cats, Birds, Other

STOMACH/INTESTINES:
Frequent heartburn/indigestion
Nausea—Vomiting
Diarrhea—Constipation
Constipation—Abdominal Pain
Blood in stool

LUNG:
Pain with deep breath
Daily cough
Daily sputum (productive)
Ever coughed up blood when_____
Persistent cough at night
Wheezing
Feeling smothered
Shortness of breath at rest/activity
Shortness of breath walking on level surface
How many yards can you walk before stopping? ____
Shortness of breath with increased activity

GENITOURINARY:
Frequent urination
Difficulty emptying bladder
Blood in urine

FOR WOMEN
Date of last period _____
Irregular periods

BONES/JOINTS
Painful joints
Swollen joints
Sore muscles
Chronic back pain
Redness of joints

SKIN:
Rash
Dry skin

EARS, EYES, NOSE, MOUTH, THROAT:
Frequent earaches
Sinus problems
Recent changes in vision
Blurred Vision
Recent hearing change
Persistent hoarseness
Sore throat
Difficulty swallowing
Frequent nose bleeds
Post nasal drainage
Frequent sneezing
Nasal congestion

HEART:
Irregular Heartbeat
Swelling of legs/ankles
(Wake up) short of breath at night
Sleep on more than one pillow? How many
Chest pain/angina at rest
Chest pain/angina with activity

NERVOUS SYSTEM:
Frequent or severe headaches
Dizziness
Loss of feeling in hands or feet
Passing out/fainting
Numbness in hands / feet

BLOOD:
Easy bruising
Bleed easily

PSYCHIATRIC:
Anxiety
Depression

ALLERGY/IMMUNE SYSTEM:
Seasonal allergies
Which season/seasons? (circle)
Fall Winter Spring Summer
Animal allergies
Skin allergy
YES/NO Ever been skin tested for allergies?

SLEEP:
Sleep Poorly
Snore
Wake frequently at night
Daytime fatigue
Restless sleep
Difficulty falling asleep

PATIENT NAME: _____ DOB: _____

For Physician Use
Please do not write
in this area

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0= would never doze
1=SLIGHT chance of dozing
2=MODERATE chance of dozing
3=HIGH chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (i.e. meeting/theater)	
As a passenger in a car for an hour without a break	
Lying down in the afternoon when circumstances permit	
Sitting and talking to someone	
In a car, while stopped for a few minutes in traffic	
Sitting quietly after lunch without alcohol.	
Total	

CIRCLE ALL MEDICAL CONDITIONS THAT APPLY.

Pneumonia
Emphysema/COPD
Adult Asthma
Childhood Asthma
Sinus Disease
Blood clot leg
Blood clot lung
Tuberculosis
YES/NO Known TB exposure
YES/NO Positivie PPD skin test
Year of last PPD:_____
Seasonal Allergies
YES/NO positive allergy testing
Rheumatic fever
Heart faiure/CHF
Heart Murmur
Coronary Artery Disease

Heart Valve Disease
Hypertension
Stroke/TIA
Diabetes/Sugar
Thyroid Disease
Osteoarthritis
Rheumatiod Arthritis
Cancer
Type:_____
Year:_____
Anemia
Stomach ulcers
Intestinal bleed
Diverticulitis
Liver Disease
Seizures
Sleep Apnea

Cpap / Bipap ❑ Yes ❑ No
Year of last sleep study
Restless Leg Syndrome
Depression/Anxiety
Drug Abuse
Alcohol Abuse
Kidney Failure

Surgeries:

Tonsillectomy
Appendectomy
Hysterectomy
Gall Bladder
CABG
Heart Valve replaced
Other not listed_____
_____

Year of: Last Flu Shot_____ Pneumonia shot/Pneumovax_____

OCCUPATIONAL HISTORY:

List previous occupations beginning with current job._____
_____

Ever had occupational exposure to the following? (circle all that apply)

Asbestos Chemical Dust Fuel exhaust Other:
Metal Dust Gas Fumes Beryllium

Please describe length of exposure and type of exposure:_____
_____

PATIENT NAME: _____ DOB: _____

For Physician Use
Please do not write
in this area

FAMILY HISTORY:

Father's Medical Problems:_____
YES/NO Still Living? Age at death:_____
Mother's Medical Problems:_____
YES/NO Still Living? Age at death:_____
Number of brothers:_____ Their medical problems:_____
Number of sisters:_____ Their medical problems:_____
Number of children:_____ Their medical problems:_____
Do you have a blood relative with the following medical problems: (circle all that apply)

Asthma	Diabetes/Sugar	Sleep Apnea
High Blood Pressure	Blood clots to the Lung	Heart Disease
Emphysema/COPD	Leg Blood Clots	Liver Disease
Chronic bronchitis	Lung Cancer	Other cancer:
Tuberculosis	Connective Tissue Disease	
Stroke	Rheumtoid Arthritis	

SOCIAL HISTORY:

Marriage status: (circle) Married Single Widowed Divorced
Educational level: (circle) Grade school High School College Post graduate

Tobacco use:

Ever used tobacco? Y/N. Year started smoking_____ Year quit smoking _____
❑ Current Everyday Smoker ❑ Someday Smoker ❑ Still using tobacco
❑ Former Smoker Year quit smoking? _____ ❑ Never A Smoker ❑ Yes ❑ No
Type of tobacco: (circle) Cigarettes Cigars Pipe Snuff / Chew

Alcohol use: (circle) Never Daily Occasional

Do you have any animals in the home? Dog Cat Bird Other:_____
Have you traveled any long distances in the past 6 months? YES/NO
Have you used a hot tub recently? YES/NO

PAST MEDICAL HISTORY:

How often have you had the following in the past year requiring antibiotics?
_____Sinusitis_____Bronchitis_____Pneumonia
Have you ever been hospitalized for your breathing? Y/N. Why_____ Where _____
Are you on oxygen? Y/N. How much?_____ How often? All the time/night/activity/sitting
Do you use CPAP/BIPAP? Y/N.
Have you ever been on life support/ventilator for more than one day? Y/N. If yes, where?_____
Do you have a nebulizer/take breathing treatments? Y/N.

Please list all MEDICATIONS on back of paper or include.