Room #_____

Critical Care & Pulmonary Consultants, P.C.

Health History

You have been scheduled for an appointment with ***Critical Care and Pulmonary Consultants, P.C.*** This health history will help us facilitate your evaluation and allow you to think about the answers to questions that you will be asked during your visit. Please fully complete this health history and bring it to your appointment. Thank you for your cooperation!

Patient Name: _____ Date of Birth: _____

Appointment date: _____ Appointment time: _____ Physician: _____

How were you referred to our pulmonary practice? _____

Reason for Visit

Briefly describe the reason for your visit and what you hope to accomplish:

_____

_____

_____

Have you had a Pneumovax Vaccine? ( ) Yes ( ) No
If Yes, when was your most current? _____

Have you had a Prevnar 13 Vaccine? ( ) Yes ( ) No
If Yes, when was your most current? _____

Have you had a Flu Vaccine? ( ) Yes ( ) No
If Yes, when was your most current? _____

Past Medical History (Please mark **All** that apply)

Diagnosis	Month/Year Onset	Diagnosis	Month/Year Onset
☐ Asthma		☐ Congenital Heart Disease	
☐ Bronchitis		☐ Abnormal EKG	
☐ Emphysema		☐ Diabetes	
☐ COPD		☐ Stroke	
☐ Hay Fever		☐ Cancer/type	
☐ Sinus Disease		☐ Blood Clots	
☐ Pneumonia		☐ Pulmonary Embolism	
☐ Interstitial Lung Disease		☐ Deep Vein Thrombosis	
☐ Pulmonary Fibrosis		☐ Bleeding disorder	
☐ Hives (urticaria)		☐ Liver Disease	
☐ Tuberculosis or + PPD test		☐ Hepatitis	
☐ Atypical Mycobacterial dis.		☐ Kidney Disease	
☐ Bronchiectasis		☐ Sleep Apnea	
☐ Chronic Cough		☐ Insomnia	
☐ Heart Attack		☐ Heartburn/GERD	
☐ High Blood Pressure		☐ Trauma	
☐ Chest Pain Angina		☐ Other	
☐ Heart Murmur		☐ Other	

☐ Congestive Heart Failure		☐ Other	

Have you ever been hospitalized? ☐ YES ☐ NO If so, for what reason?

Admission Date	Diagnosis/Problem	Length of Stay	Comments

Family History

	Alive & Well	Deceased? If so, at what age?	Cause of Death:	Health Problems:
Mother				
Father				
Sister				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				
Child				
Child				
Child				

Please list and **surgeries** you have had and the approximate date of the surgery.

Admission Date	Type of Surgery	Comments

Drug allergies / Adverse Drug Reactions if **None** please **Check Here** ☐

Name of Medication	Reaction	Comment

Are you allergic to EGGS? ☐ Yes ☐ No ☐ Do Not Know

Are you allergic to IODINE? ☐ Yes ☐ No ☐ Do Not Know

Are you allergic to CONTRAST DYE? ☐ Yes ☐ No ☐ Do Not Know

Have you ever had skin testing or allergy shots? ☐ YES ☐ NO ☐ DO NOT KNOW

Medications

Please list your current oral and inhaled medications including medication name, dose, and number of times per day you take the medication, and mark whether you take it "regularly" or only "as needed," Please list any "over the counter" medications

Medication (Oral and Inhaled)	Tablet strength or # puffs	# of Times per Day	Regular Use	Only "as needed"	Comments
			□	□	
			□	□	
			□	□	
			□	□	
			□	□	
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			□	□	
			□	□	
			□	□	

Do you use oxygen? □ Yes □ No (If **Yes**, please mark **All** that apply)

Time of Day	Date Started	Liters/minute	Comments
□ Sleep			
□ Activity			
□ Continuous			
□ Other			

Social History

Marital Status: □ Single □ Married/Partner □ Divorced □ Separated □ Widowed

Occupation _____

Any history of toxin or chemical exposure related to current or former occupation or hobbies? □ Yes □ No

If so, please describe _____

Smoking History

- □ Never smoker
- □ Current or Former smoker
  - Age started ____ Age stopped ____
  - Average # packs per day _____
  - Current # packs per day _____
- □ Other Tobacco Products
  - Type _____
  - Amount

Personal Habits

Do you drink alcohol?	□Yes	□No
If so, what type and how much?		
Ever used illicit drug?	□Yes	□No
If so, when and what substance?		

List any pets you may have: _____
Have any of your pets died recently? _____
List all of your job experiences from earliest to current

_____
_____

List any exposures to what you think might be a toxic substance(s)

_____
_____

List any hobbies you may have

_____
_____

List any places you may have traveled in the past two years

_____
_____

List any time you have spent in the military_____

Exercise activity _____

Do you have an advanced care directive or surrogate care provider? □Yes □ No. If Yes, please describe below.

_____

Current or Recent Symptoms:

		Gastrointestinal:	( ) Indigestion
Constitution:	( ) Night sweats or fevers		( ) Diarrhea or constipation
	( ) Chills		( ) Choking
	( ) Abnormal sweating		( ) Abdominal pain
	( ) Weight loss/gain		( ) Difficulty swallowing
			( ) Blood in stools
Eyes:	( ) Visual difficulty		
		Genitourinary:	( ) Increased urinary frequency at night
ENTM:	( ) Nasal congestion or blockage		( ) Difficulty urinating
	( ) Nose bleeds		
	( ) Ear pain/infections	**Musculoskeletal:**	( ) Joint Pain
	( ) Mouth sores		
		Skin:	( ) Pain or color change of hands with cold exposure
Respiratory:	( ) Shortness of breath		( ) Swelling in legs/feet
	( ) Shortness of breath at night		( ) Skin rash
	( ) Wheezing		
	( ) Shortness of breath around animals	**Neurological:**	( ) Tremors
	( ) Coughing up blood		( ) New weakness or numbness
	( ) Cough		( ) Headaches
	( ) Phlegm production		
	( ) Shortness of breath that is worse at work	**Endocrine:**	( ) Infertility/impotence
			( ) Sexual problems
Cardiovascular:	( ) Chest pain		
	( ) Heart palpitations	**Heme/Lymp**	( ) Bruising/Bleeding
	( ) Loss of consciousness or passing out		( ) New Swollen Lymph Node
	( ) Irregular heart beat		
	( ) Pain in legs with walking	**Psychological:**	( ) Depression

Sleep History

Yes	No	
☐	☐	Snore loudly
☐	☐	Stop breathing during sleep
☐	☐	Choking or gasping during sleep
☐	☐	Wake refreshed
☐	☐	Wake with headaches
☐	☐	Driving accidents or near accidents due to sleeping
☐	☐	Tired or fatigued during usual daytime activities
☐	☐	Kicking or twitching during sleep
☐	☐	Restless, tingling, or crawling feeling in legs
☐	☐	Trouble falling asleep (for how long? _____)
☐	☐	Trouble returning to sleep (for how long? _____)
☐	☐	Weak feeling in arms or legs when emotional
☐	☐	Inability to move (paralysis) on waking

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 for Dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

I have reviewed: _____ Date: _____