INTERVAL HEALTH HISTORY

You have been scheduled for an appointment with ***Critical Care and Pulmonary Consultants, P.C.***. This interval 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. Thank you for your cooperation!

CHANGE IN DEMOGRAPHIC INFORMATION SINCE LAST VISIT

☐ **Check box if no change or fill out information if changed**

Name: _____ Date of Birth: _____

Address: _____ Home Phone: (____) _____

_____ Work Phone: (____) _____

Emergency Contact: (____) _____ Relationship: _____

REFERRING PHYSICIAN INFORMATION IF CHANGED SINCE LAST VISIT:

☐ **Check box if no change or fill out information if changed**

Referring physician is the individual to whom correspondence will be sent.

Referring or Primary Care Physician:

_____

Name

_____

Address

_____

City, State, Zip Code

(____) _____ (____) _____

Phone Fax

Other Physician: ☐ Please check this box if you would like us to send correspondence

_____

Name

_____

Address

_____

City, State, Zip Code

(____) _____ (____) _____

Phone Fax

REASON FOR VISIT or ANY NEW BREATHING SYMPTOMS SINCE LAST VISIT:
Briefly describe the reason for your visit and what you hope to accomplish:

Do you use Oxygen? ☐ YES ☐ NO

Name of Home Health / Oxygen Company:

Immunizations (Please mark **ALL** that apply)

Type	Date	Comment
☐ Pneumonia Vaccine		
☐ Flu Shot		
☐ Prevnar		

Have you ever been **hospitalized or had Surgery SINCE LAST VISIT**? ☐ YES ☐ NO If so, for what reason?

Admission date	Diagnosis/Problem	Length of stay	Comments

SOCIAL HISTORY

Smoking History since last visit:

Drug or Alcohol use since last visit:

REVIEW OF SYSTEMS

What **SYMPTOMS** are you current experiencing? (Please answer **YES or NO** for each symptom)

Y	N		Comment	Y	N		Comment
Constitutional							
		No change				Chills	
		Fever				Weight loss	
Skin							
		Nail Changes				Changes in Hair Growth	
Head, Eyes, Ears, Nose, Mouth, Throat							
		No change				Hoarseness	
		Nose bleeds				Sinus congestion	
Cardiovascular							
		No Change				Ankle swelling	
		Palpitations				Chest pain	
Gastrointestinal							
		No Change				Diarrhea	
		Abdominal Pain				Nausea/Vomiting	
		Bloody Stools				Choking/Trouble Swallowing	
Genitourinary							
		No Change					
		Painful Urination				Broody urine	
		Difficulty Urinating				Incontinence	
Musculoskeletal							
		No Change				Joint Pain	
		New Weakness					
Neurologic							
		No Change				Memory loss	
		Fainting				Tremors	
		Weakness					
Psychiatric							
		No Change				Anxiety	
		Depression				Panic/Fear Attacks	
Hematologic							
		No Change				Bleeding	
		Easy Bruising				Swollen Glands	
		Blood Clots					
Endocrine							
		No change				High blood sugar	
		Sweating					

Please use the space provided for additional history or for other information that you would like us to know.
Sincerely,

Critical Care and Pulmonary Consultants, P.C.