

Central Florida Pulmonary Group, P.A.

Account

Patient's Name	Age	Marital Status S M D W	Today's Date
Current Occupation	Family Physician (PCP)	Phone	
If Retired, Previous Occupation	Referring Physician	Phone	

Main reason for today's visit, and when did you first notice this problem?

Please check any current problems you are having. If yes, please explain.

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Hay fever (allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Cough <input type="checkbox"/> with phlegm <input type="checkbox"/> with blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Color: _____
<input type="checkbox"/> Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Recent weight change	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Sleeping disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

MEDICAL HISTORY FORM

ALLERGIES: Please check any current allergies you have.

<input type="checkbox"/> Ace Inhibitors	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Dairy Products	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Mold	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Pet Dander	<input type="checkbox"/> Prednisone	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> X-ray Dye	<input type="checkbox"/> No Known Allergies
<input type="checkbox"/> Other: _____				

MEDICATION: Prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies or reactions to medications: _____

Date of your most recent IMMUNIZATION: Influenza (flu shot) _____ Pneumovax (pneumonia) _____ Other: _____

TESTING: Please check any recent testing you had.

Type of Test	When	Where	Results if known
TB Skin Test	_____	_____	_____
Chest X-ray/CT Scan	_____	_____	_____
Pulmonary Function Test (PFT)	_____	_____	_____

PAST SURGICAL/HOSPITALIZATION HISTORY: Please list all prior operations/hospitalization (with dates).

Type of Surgery/Hospitalization	Where (e.g. name of hospital or facility)	Date

PAST MEDICAL HISTORY: Please check if you have ever been diagnosed with any of the following.

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirations | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> Cardiac Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fissure | <input type="checkbox"/> GERD/Heart Burn |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hodgkin's Disease |
| <input type="checkbox"/> Hyperactive Airway | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Obesity | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pneumothorax | <input type="checkbox"/> Pulmonary Emboli |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Raynaud's Phenomenon | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Stridor | <input type="checkbox"/> Stroke, TIA, CVA | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other: _____ | | | |

FAMILY HISTORY: Please indicate the current status of your immediate family members. Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

- | | | | |
|---------------------|-------|----------------------|-------|
| Addison's disease | _____ | High cholesterol | _____ |
| Alcoholism | _____ | Hypertension | _____ |
| Alzheimer's disease | _____ | Kidney disease | _____ |
| Asthma | _____ | Lupus | _____ |
| Autoimmune disorder | _____ | Obesity | _____ |
| Cancer (list type) | _____ | Osteoporosis | _____ |
| Cardiovascular | _____ | Respiratory disease | _____ |
| COPD | _____ | Rheumatoid arthritis | _____ |
| Cystic fibrosis | _____ | Schizophrenia | _____ |
| Diabetes | _____ | Sickle cell disease | _____ |
| Emphysema | _____ | Stroke | _____ |
| Fibromyalgia | _____ | Thyroid disease | _____ |
| Heart problems | _____ | Tuberculosis | _____ |
| Hepatitis | _____ | Other: | _____ |

SOCIAL HISTORY

Tobacco Use

- Cigarettes: Never Quit Date _____
 Current Smoker: packs/day _____ # of years _____
 Other tobacco: Pipe Cigar Snuff Chew
 Are you interested in quitting? Yes No

Alcohol Use

- Do you drink alcohol? Yes # of drinks/week _____ No

Drug Use

- Do you use recreational drugs? Yes No

Caffeine Use

- Coffee/tea/soda _____ cups/day None

Exposures

- | | | |
|---|---|--|
| <input type="checkbox"/> asbestos while working in/as | <input type="checkbox"/> A/C | <input type="checkbox"/> construction, |
| | <input type="checkbox"/> a mechanic, | <input type="checkbox"/> a pipefitter |
| | <input type="checkbox"/> a shipyard | |
| <input type="checkbox"/> burns wood in home | <input type="checkbox"/> chemical/toxin | |
| <input type="checkbox"/> oil or kerosene burning heater in home | <input type="checkbox"/> radiation | |
| <input type="checkbox"/> dust | <input type="checkbox"/> coal dust | |
| <input type="checkbox"/> carpenter's wood dust | <input type="checkbox"/> ammonia | |
| <input type="checkbox"/> chemical fumes or gases | <input type="checkbox"/> silica | |
| <input type="checkbox"/> soldering/welding | <input type="checkbox"/> agent orange | |
| <input type="checkbox"/> UV overexposure | <input type="checkbox"/> chlorine | |
| <input type="checkbox"/> chemical fumes | <input type="checkbox"/> feathers | |
| <input type="checkbox"/> mold growing in house | <input type="checkbox"/> fiberglass | |
| <input type="checkbox"/> tobacco exposure | <input type="checkbox"/> Animals/Pets | |