

Western Carolina Pulmonary Patient History Form

Patient's Name: _____ Date: _____

Briefly explain the reason for your visit: _____

Please indicate if you have been diagnosed with any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Deep venous thrombosis | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> BPH | <input type="checkbox"/> GERD | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Bronchiectasis | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Restless Legs Syndrome |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Carotid stenosis | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Anxiety | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Obesity | <input type="checkbox"/> _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> _____ |

Surgical History: Please list any surgeries you have had, including dates:

Family History:

- | | | | |
|---------------------------------------|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |

Social History:

Occupation: _____ Retired? Year: _____

Smoking: Have you ever smoked? Yes No
Age started: _____ Age stopped: _____ Years smoked: _____
Average packs per day: _____
If still smoking, have you tried to quit? _____
Methods used to try to quit smoking: Nicotine patches Nicotine Gum
 Nicotrol Inhaler Zyban/Wellbutrin Chantix Other _____

Alcohol: Do you drink alcohol? Yes No
If you drink alcohol, how often do you drink? _____ How many drinks? _____
What type of alcohol do you drink? _____

Caffeine: Do you drink caffeine? Yes No
What form? Coffee Tea Soft drinks Other _____
How many caffeinated beverages do you drink in a day? _____

Review of Systems

Please indicate if you have **recently** experienced any of these symptoms.

Constitutional:

- Chills
- Fatigue
- Fevers
- Night Sweats
- Weight gain
- Weight loss

Ears:

- Ear pain
- Hearing problems
- Ringing in ears

Nose:

- Nasal congestion
- Nasal ulcers
- Nosebleeds
- Runny nose
- Sinusitis

Throat:

- Dry mouth
- Hoarseness
- Mouth sores
- Sore throat
- Sore tongue

Cardiovascular:

- Chest pain
- Leg swelling
- Shortness of breath lying flat
- Waking up with sudden shortness of breath
- Palpitations
- Tachycardia
- Leg pain while walking
- Varicose Veins

Respiratory:

- Cough (acute)
- Cough (chronic)
- Shortness of breath
- Wheezing
- Coughing blood
- Daily mucous production
- TB exposure

Gastrointestinal:

- Abdominal pain
- Indigestion
- Heartburn
- Acid Reflux
- Loss of appetite
- Nausea
- Vomiting
- Constipation
- Diarrhea

Genitourinary:

- Painful urination
- Blood in urine
- Frequent urinary infections
- Urination at night
- Frequent urination
- Urinary incontinence

Musculoskeletal:

- Arthralgias
- Back pain
- Joint pain
- Joint stiffness
- Limb pain

Skin:

- Rashes
- Itching
- Dry skin
- Jaundice
- Thin skin
- Easy bruising

Neurological:

- Dizziness
- Fainting
- Headaches
- Tremors
- Seizures
- Numbness
- Tingling
- Weakness
- Migraines

Endocrine:

- Cold Intolerance
- Heat Intolerance
- Excessive sweating
- Excessive thirst
- Excessive hunger

Allergy:

- Allergy shots
- Seasonal allergies
- Perennial allergies
- Allergic rhinitis
- Hives

Psychiatric:

- Anxiety
- Depression
- Mood swings
- Stress
- Difficulties concentrating
- Memory problems

Hematological

- Anemia
- Swollen lymph nodes
- Easy bruising
- Easy bleeding
- Transfusions

Sleep:

- Snoring
- Stopping breathing in sleep
- Frequent awakenings
- Excessive sleepiness
- Excessive fatigue
- Insomnia
- Restless legs
- Frequent leg kicks during sleep