**PULMONARY & CRITICAL CARE ASSOCIATES**

# MEDICAL INFORMATION SHEET

(Please Print)

| Today's date: | |
|---|---|
| **PATIENT INFORMATION** | |
| Name: | |
| Date of Birth: | Place of Birth: |

| **CHIEF COMPLAINT** |
|---|
| (What brings you into the office today?) |
| Chief Complaint: |
| Duration of Symptoms: |

| **IMMUNIZATIONS** | |
|---|---|
| (Record the date/year of last vaccine, if known) | |
| Flu Vaccine: | Pneumonia Vaccine: |

| **PAST MEDICAL HISTORY** | | | |
|---|---|---|---|
| (Please check any of the conditions that you have now or have had in the past) | | | |
| Acid Reflux | Arthritis | Asthma | Cirrhosis |
| Congestive Heart Failure | COPD | Diabetes | Deep Vein Thrombosis (DVT) |
| Heart Attack | High Cholesterol | Hypertension | Hypothyroidism |
| Insomnia | Kidney Failure | Lung Cancer | Narcolepsy |
| Obesity | Peptic Ulcer Disease | Pleural Effusion | Pneumonia |
| Pulmonary Embolism | Pulmonary Fibrosis | Sarcoidosis | Seasonal Allergy |
| Seizures | Sinusitis | Sleep Apnea | Stroke |
| Tuberculosis | Cancer (please specify): | Other (please specify): | |

| **PAST SURGICAL HISTORY** | | | |
|---|---|---|---|
| (Please check all that apply, specify where necessary and indicate year) | | | |
| Appendectomy (appendix) | Bladder (specify) | Bowels (specify) | Cesarean Section |
| Cholecystectomy (gallbladder) | Heart (specify) | Hysterectomy | Lung (specify) |
| Ovaries (specify) | Pacemaker (specify) | Prostate (specify) | Sinus (specify) |
| Tonsils | Other | | |

| **ALLERGIES** | |
|---|---|
| **Allergies to Medication (Describe reaction)** | **Allergies to Food/Other (Describe reaction)** |
| | |
| | |
| | |
| | |

| Name: | Date of Birth: |
|---|---|

## SOCIAL HISTORY

(Please note answers to questions are part of your permanent medical record)

| | | |
|---|---|---|
| **Cigarette Smoking:** | | |
| Have you ever smoked? | If yes, for how many years? | How many packs per day? |
| When did you quit? | What things (nicotine gum, patch, etc.) have you tried to help you quit? | |
| **Illicit Drug Use:** | | |
| Have you ever used illegal drugs? | What did you use? | When was the last time? |
| **Alcohol Use:** | | |
| Do you drink alcohol? | How much? | How often? |
| **Caffeine Use:** | | |
| How often do you consume caffeine?<br>Daily Rarely Never | What sources? (i.e. soda, coffee, tea, etc.) | How much? |
| **General History"** | | |
| Do you have pets at home? If yes, what pets? | | |

## FAMILY MEDICAL HISTORY

Please list your immediate family members (parents, grandparents, siblings, children) their relationship to you, along with their health status (living or deceased) and any related medical conditions (especially pulmonary conditions such as emphysema, asthma and lung cancer)

| Family Member Name | Relation | Health Status | Medical Conditions |
|---|---|---|---|
| | | Living / Deceased | |
| | | Living / Deceased | |
| | | Living / Deceased | |

## OCCUPATIONAL HISTORY

Please list your last two jobs/occupations and include any occupational exposure to solvents, heavy metals, asbestos, organic or inorganic dusts or any other materials which you believe may be contributing to your lung status.

| Job Description | Exposures |
|---|---|
| | |
| | |

## MEDICATIONS

Please list all medicines you are currently taking, prescription, over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin). If additional space is needed, please continue on the back.

| Name of Medication / Dose | Directions | Prescribing Doctor |
|---|---|---|
| | | |
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