TO BE COMPLETED BY PATIENT

PULMONARY AND CRITICAL CARE SPECIALISTS OF NORTHERN VIRGINIA, P.C.

NEW PATIENT HISTORY

PATIENT NAME: _____ **DATE:** _____

AGE: _____ **DOB:** _____ **SEX:** ☐ M ☐ F

PULMONARY REVIEW OF SYMPTOMS AND HISTORY

Please check all that apply.

Wheezing:
- ☐ Following a cold
- ☐ With exercise
- ☐ At rest
- ☐ Seasonally (Spring/Summer/Fall/Winter)

Shortness of Breath:
- ☐ During light/moderate/strenuous exercise
- ☐ During normal activity
- ☐ While at rest/awaken at night

How many blocks on level ground can you walk?
< 1_____ 1 – 3_____ 4+_____
How many flights of stairs can you climb? _____

- ☐ Intermittent cough (not related to a common cold)
- ☐ Frequent cough in the morning
- ☐ Sputum production _____tablespoons per day
- ☐ Sputum color_____
- ☐ Coughing up blood _____tablespoons per day
- ☐ Chest congestion/tightness

- ☐ Exposure to TB
- ☐ Positive TB skin test in the past
  Date: _____
  Were you treated?_____
- ☐ Pneumonia
  Date: _____

Sleep:
- ☐ Snoring
- ☐ Daytime sleepiness

☐ Witnessed Stoppage of Breathing at Night

Smoking:
- ☐ Never smoked
- ☐ Quit smoking
  Date: _____
  Average packs per day: _____
  Number of years you smoked: _____
- ☐ Currently smoking
  Average packs per day: _____
  Number of years smoked: _____

Date of your last Chest X-ray: _____
Where?_____
Date of your last pneumonia vaccine: _____
Date of your last flu vaccine: _____
Date of your last shingles vaccine: _____
Have you ever had a blood transfusion? ☐ Y ☐ N
If so, date of transfusion(s) _____

Allergies: (Please list medication allergies separately on the Medication List.)
- ☐ Food _____
- ☐ Shellfish/Iodine/Contrast or Dye
- ☐ Environmental/Seasonal Allergies _____
- ☐ Latex

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NEW PATIENT HISTORY

PATIENT NAME: _____ **DATE:** _____

ADDITIONAL REVIEW OF SYMPTOMS (over the past six months) *Please check all that apply.*

Constitutional
- ☐ Fever, sweats or chills
- ☐ Loss of appetite
- ☐ Weight Loss (how much?_____)
- ☐ Weight Gain (how much?_____)

Eyes
- ☐ Eyeglasses or Contacts
- ☐ Double Vision
- ☐ Redness
- ☐ Discharge

Ears, Nose, Mouth, Throat
- ☐ Earaches
- ☐ Hearing Aid
- ☐ Nose or Sinus Problems
- ☐ Difficulty Swallowing

Cardiovascular
- ☐ Chest Pain/Tightness
- ☐ Irregular/Rapid Heartbeat
- ☐ Heart Murmur
- ☐ High Cholesterol

Gastrointestinal
- ☐ Heart Burn/Indigestion
- ☐ Diarrhea/Constipation
- ☐ Nausea/Vomiting
- ☐ Blood in Bowel Movements

Genitourinary
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Frequent urination at night _____ times per night

Musculoskeletal
- ☐ Stiffness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Aches

Integumentary
- ☐ Breast Discomfort
- ☐ Rashes/Skin Problems
- ☐ Swelling in Extremities
- ☐ Skin Discoloration

Neurologic
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Dizziness/Fainting

Psychiatric
- ☐ Sleep Difficulty
- ☐ Anxiety
- ☐ Mood Changes
- ☐ Depression

Endocrine
- ☐ Excessive Thirst
- ☐ Diabetes
- ☐ Thyroid Disorder

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Excessive Bleeding
- ☐ Bruise Easily
- ☐ Anemia

PAST MEDICAL/SURGICAL HISTORY

Birthplace: _____

- ☐ Lung Surgery _____ Date _____
- ☐ Heart Surgery _____ Date _____
- ☐ Other Surgeries _____ Date _____
- _____ Date _____

- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ HIV Disease

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Sickle Cell
- ☐ Diabetes

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NEW PATIENT HISTORY

PATIENT NAME: _____ **DATE:** _____

SOCIAL HISTORY

Are you currently employed? ☐ **Y** ☐ **N** **FT**_____**PT**_____ **What is your occupation?**_____

Have you ever been exposed to any of the following?:

☐ Animals
☐ Asbestos
☐ Birds/Droppings
☐ Dust/Construction
☐ Fumes
☐ Paint
☐ Pesticides/Other Chemicals
☐ Other _____

Do you have animals at home?_____ **What types?** _____

Do you drink alcohol? ☐ **Y** ☐ **N** **If yes, approximately how many drinks do you consume per week?** _____

Have you traveled in the past year? _____ **Where?** _____

FAMILY HISTORY

Father: Alive? ☐ **Y** ☐ **N** **Age** _____ **Cause of Death**_____ **Died at What Age?**_____

Mother: Alive? ☐ **Y** ☐ **N** **Age** _____ **Cause of Death**_____ **Died at What Age?**_____

If you have children, please list gender and age of each child:

Are any of the following conditions present in a close family member such as your mother, father, sibling or child?

☐ Asthma
☐ Bronchitis
☐ Blood Clots
☐ Cancer
☐ Diabetes
☐ Emphysema
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Sickle Cell Anemia
☐ Stroke
☐ Tuberculosis
☐ Other_____

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