

STATCARE PULMONARY CONSULTANTS

For Physician Use
Please do not write
in this area

PATIENT NAME: _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ MR# _____

REFERRING DOCTOR: _____

PAST MEDICAL HISTORY:

How often have you had the following in the past year requiring antibiotics?

_____ Sinusitis _____ Bronchitis _____ Pneumonia

YES/NO Have you ever been hospitalized for your breathing? If yes, where _____

YES/NO Do you use Oxygen? If yes, how much? _____ YES/NO do you have a home nebulizer machine?

How often do you use your oxygen? ___All the time___ Only at night___ Only when I need it___ Only with activity

YES/NO Ever been on life support/ventilator for more than on day? If yes, where: _____

CHECK ALL MEDICAL CONDITIONS YOU HAVE NOW OR IN THE PAST:

- | | |
|---------------------------------------|--------------------------------|
| _____ Pneumonia | _____ Anemia |
| _____ Emphysema/COPD | _____ Stomach ulcers |
| _____ Adult Asthma | _____ Intestinal bleed |
| _____ Childhood Asthma | _____ Diverticulitis |
| _____ Sinus Disease | _____ Liver Disease |
| _____ Blood clot leg | _____ Seizures |
| _____ Blood clot lung | _____ Sleep Apnea |
| _____ Tuberculosis | _____ YES/NO Use CPAP/BIPAP? |
| _____ YES/NO Known TB exposure | _____ Year of last sleep study |
| _____ YES/NO Positive PPD skin test | _____ Restless Leg Syndrome |
| _____ Year of last PPD: _____ | _____ Depression/Anxiety |
| _____ Season Allergies | _____ Drug Abuse |
| _____ YES/NO positive allergy testing | _____ Alcohol Abuse |
| _____ Rheumatic fever | _____ Kidney Failure |
| _____ Heart failure/CHF | _____ <u>Surgeries:</u> |
| _____ Heart Murmur | _____ Tonsillectomy |
| _____ Coronary Artery Disease | _____ Appendectomy |
| _____ Heart Valve Disease | _____ Hysterectomy |
| _____ Hypertension | _____ Gall Bladder |
| _____ Stroke/TIA | _____ CABG |
| _____ Diabetes/Sugar | _____ Heart Valve replaced |
| _____ Thyroid Disease | _____ Other _____ |
| _____ Osteoarthritis | |
| _____ Rheumatoid Arthritis | |
| _____ Cancer | |
| _____ Type: _____ | |
| _____ Year: _____ | |

List any other medical problem not listed above _____

Year of 1st vaccination _____ influenza _____ Pneumonia shot/Pneumovax

SOCIAL HISTORY:

Marriage status: (circle) Married Single Widowed Divorced

Educational level: (circle) Grade school High School College Post graduate

Tobacco use:

YES/NO Ever used tobacco? _____ Year started smoking _____ Year quit smoking _____

YES/NO Still using tobacco? _____ Year quit smoking _____

Type of tobacco: (circle) Cigarettes Cigars Pipe Snuff / Chew

Alcohol use: (circle) Never Daily Occasional

FAMILY HISTORY:

Father's Medical Problems: _____

YES/NO Still Living? _____ Age at death: _____

Mother's Medical Problems: _____

YES/NO Still Living? _____ Age at death: _____

Number of brothers: _____ Their medical problems: _____

Number of sisters: _____ Their medical problems: _____

Number of children: _____ Their medical problems: _____

Do you have a blood relative with the following medical problems: (circle all that apply)

- | | | |
|---------------------|---------------------------|---------------|
| Asthma | Diabetes/Sugar | Sleep apnea |
| High Blood Pressure | Blood clots to the lung | Heart Disease |
| Emphysema/COPD | Leg blood clots | Liver Disease |
| Chronic bronchitis | Lung Cancer | Other cancer: |
| Tuberculosis | Connective Tissue Disease | |
| Stroke | Rheumtoid Arthritis | |

OCCUPATIONAL HISTORY:

List previous occupations beginning with current job. _____

Ever had occupational exposure to the following? (circle all that apply)

- | | | | |
|------------|---------------|--------------|--------|
| Asbestos | Chemical Dust | Fuel exhaust | Other: |
| Metal Dust | Gas Fumes | Beryllium | |

Please describe length of exposure and type of exposure: _____

PHYSICAL SYMPTOMS: (Please check all that apply. Write in description if needed)

GENERAL:

- _____ Weight gain over past year, how much? _____
- _____ Weight loss over past year, how much? _____
- _____ YES/NO intentional?
- _____ Sleep Poorly
- _____ Snore
- _____ Awake frequently at night
- _____ Daytime sleepiness
- _____ Daytime fatigue
- _____ Restless sleep
- _____ Difficulty falling asleep
- _____ Fever
- _____ Chills
- _____ Poor appetite
- _____ Unusual swelling/lumps
- _____ Steroid use in the past year (prednisone, decadron, medrol)
- _____ Any pets in the home (circle): bird dog cat other
- _____ Long distance travel in past 6 months
- _____ Recent hot tub use

EARS, NOSE, MOUTH, THROAT:

- _____ Frequent earaches
- _____ Sinus problems
- _____ Nasal congestion
- _____ Postnasal drainage
- _____ Frequent sneezing
- _____ Persistent hoarseness
- _____ Sore throat
- _____ Difficulty swallowing
- _____ Frequent nose bleeds

HEART:

- _____ Irregular Heartbeat
- _____ Swelling of legs/ankles
- _____ Wake up short of breath at night
- _____ Sleep on more than one pillow
- _____ Chest pain/angina at rest
- _____ Chest pain/angint with activity

STOMACH/INTESTINES:

- _____ Frequent heartburn/indigestion
- _____ Nausea
- _____ Diarrhea
- _____ Constipation
- _____ Abdominal pain
- _____ Blood in stool

EYES:

- _____ Recent change in vision
- _____ Wear glasses/contact

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LUNG:

- _____ Pain with deep breath
- _____ Daily cough
- _____ Daily sputum
- _____ Ever coughed up blood
- _____ Persistent cough at night
- _____ Wheezing
- _____ Smothering
- _____ Shortness of breath at rest
- _____ Shortness of breath walking on level surface
- _____ How many yards can you walk before stopping? _____
- _____ Shortness of breath with increased activity

GENITOURINARY:

- _____ Frequent urination
- _____ Difficulty emptying bladder
- _____ Blood in urine

FOR WOMEN

- _____ Date of last period _____
- _____ Irregular periods

BONES/JOINTS

- _____ Painful joints
- _____ Swollen joints
- _____ Sore muscles
- _____ Chronic back pain

SKIN:

- _____ Rash
- _____ Dry skin

NERVOUS SYSTEM:

- _____ Frequent or severe headaches
- _____ Dizziness
- _____ Numbness in hands or feet
- _____ Loss of feeling in hands or feet
- _____ Passing out/fainting

BLOOD:

- _____ Easy bruising
- _____ Bleed easily

PSYCHIATRIC:

- _____ Anxiety
- _____ Depression

ALLERGY/IMMUNE SYSTEM:

- _____ Seasonal allergies
- _____ Which season/seasons? (circle)
- _____ Fall Winter, Spring Summer
- _____ Animal allergies
- _____ Skin allergy
- _____ YES/NO ever had skin testing for allergies? _____

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

- 0= would never doze
- 1=SLIGHT chance of dozing
- 2=MODERATE chance of dozing
- 3=HIGH chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (i.e. meeting/theater)	
As a passenger in a car for an hour without a break	
Lying down in the afternoon when circumstances permit	
Sitting and talking to someone	
In a car, while stopped for a few minutes in traffic	
Sitting quietly after lunch without alcohol.	
Total	