PHYSICAL SYMPTOMS: (Please circle 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?
- Fever_______ Chills________ Sweats________
- Poor appetite
- Unusual swelling/lumps
- Steroid use in the past year (prednisone, decadron, medrol)
- Recent hot tub use
- Long distance travel in the past 6 months
- Pets at home
  - Dogs, Cats, Birds, Other

STOMACH/INTESTINES:
- Frequent heartburn/indigestion
- Nausea—Vomiting
- Diarrhea—Constipation
- Constipation—Abdominal Pain
- Blood in stool

LUNG:
- Pain with deep breath
- Daily cough
- Daily sputum (productive)
- Ever coughed up blood when_______
- Persistent cough at night
- Wheezing
- Feeling smothered
- Shortness of breath at rest/activity
- 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
- Redness of joints

SKIN:
- Rash
- Dry skin

EARS, EYES, NOSE, MOUTH, THROAT:
- Frequent earaches
- Sinus problems
- Recent changes in vision
- Blurred Vision
- Recent hearing change
- Persistent hoarseness
- Sore throat
- Difficulty swallowing
- Frequent nose bleeds
- Post nasal drainage
- Frequent sneezing
- Nasal congestion

HEART:
- Irregular Heartbeat
- Swelling of legs/ankles
- (Wake up) short of breath at night
- Sleep on more than one pillow? How many
- Chest pain/angina at rest
- Chest pain/angina with activity

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

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 been skin tested for allergies?

SLEEP:
- Sleep Poorly
- Snore
- Wake frequently at night
- Daytime fatigue
- Restless sleep
- Difficulty falling asleep
**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

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

**CIRCLE ALL MEDICAL CONDITIONS THAT APPLY.**

- Pneumonia
- Emphysema/COPD
- Adult Asthma
- Childhood Asthma
- Sinus Disease
- Blood clot leg
- Blood clot lung
- Tuberculosis
- YES/NO Known TB exposure
- YES/NO Positive PPD skin test
- Year of last PPD:
- Year of last sleep study
- Restless Leg Syndrome
- Depression/Anxiety
- Drug Abuse
- Kidney Failure
- Cancer
- Rheumatoid Arthritis
- Alcohol Abuse
- Year of:
- Tonsillectomy
- Appendectomy
- Hysterectomy
- Gall Bladder
- CABG
- Heart Valve replaced
- Other not listed
- Type: ____________
- Pericarditis
- Gastroenteritis
- Hypothyroidism
- Myocarditis
- Polycystic Ovary
- Diabetes
- Type: ____________
- Year: ____________
- Cancer
- Year: ____________
- Anemia
- Year: ____________
- Stomach ulcers
- Year: ____________
- Intestinal bleed
- Year: ____________
- Diverticulitis
- Year: ____________
- Liver Disease
- Year: ____________
- Seizures
- Year: ____________
- Sleep Apnea
- Year: ____________

**SURGERIES:**
- Pneumonia shot/Pneumovax

**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:
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 disease:
Tuberculosis                 Connective Tissue Disease                
Stroke                      Rheumatoid Arthritis

SOCIAL HISTORY:
Marriage status: (circle)     Married     Single     Widowed     Divorced
Educational level: (circle)     Grade school     High School     College     Post graduate
Tobacco use:
Ever used tobacco? Y/N.     Year started smoking__________ Year quit smoking ______
☐ Current Everyday Smoker     ☐ Someday Smoker     ☐ Still using tobacco
☐ Former Smoker     Year quit smoking? ______     ☐ Never A Smoker     ☐ Yes ☐ No
Type of tobacco: (circle)     Cigarettes     Cigars     Pipe      Snuff / Chew
Alcohol use: (circle)     Never     Daily     Occasional
Do you have any animals in the home?  Dog    Cat    Bird    Other:_____________________________
Have you traveled any long distances in the past 6 months? YES/NO
Have you used a hot tub recently? YES/NO

PAST MEDICAL HISTORY:
How often have you had the following in the past year requiring antibiotics?
   _____Sinusitis  _____Bronchitis  _____Pneumonia
Have you ever been hospitalized for your breathing? Y/N. Why________________________ Where________
Are you on oxygen? Y/N. How much?_______ How often? All the time/night/activity/sitting
Do you use CPAP/BIPAP? Y/N.
Have you ever been on life support/ventilator for more than one day? Y/N. If yes, where?_________________
Do you have a nebulizer/take breathing treatments? Y/N.

Please list all MEDICATIONS on back of paper or include.