

**South Seminole
Pulmonary Critical Care
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MEDICAL HISTORY

WHAT BRINGS YOU TO THE DOCTOR TODAY? _____

WHEN DID YOU FIRST NOTICE THIS PROBLEM? _____

DO YOU HAVE ANY OF THE FOLLOWING? (IF YES, PLEASE EXPLAIN)

SHORTNESS OF BREATH	YES	NO	_____
WHEEZING	YES	NO	_____
COUGH	YES	NO	_____
COUGH UP PHLEGM	YES	NO	_____
COUGH UP BLOOD	YES	NO	_____
CHEST TIGHTNESS	YES	NO	_____
CHEST PAIN	YES	NO	_____
HAYFEVER/ALLERGIES	YES	NO	_____
RECENT FEVERS	YES	NO	_____
POST NASAL DRAINAGE	YES	NO	_____
DIFICULTY SWALLOWING	YES	NO	_____
INDIGESTION/HEARTBURN	YES	NO	_____
NIGHT SWEATS	YES	NO	_____
SNORING	YES	NO	_____
RECENT WEIGHT CHANGE	YES	NO	_____

DO YOU SMOKE? YES NO HOW MANY YRS? _____ PACKS/DAY _____
 HAVE YOU EVER? YES NO HOW MANY YRS? _____ WHEN DID YOU QUIT _____
 DOES ANY ONE IN YOUR HOUSEHOLD SMOKE? YES NO
 DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____
 DO YOU DRINK CAFFIENATED BEVERAGES? YES NO HOW MUCH _____

RESPIRATORY HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? (PLS EXPLAIN)

ASTHMA	YES	NO	_____	HAYFEVER	YES	NO	_____
BROCHITIS	YES	NO	_____	SINUSITIS	YES	NO	_____
EMPHYSEMA	YES	NO	_____	PLEURISY	YES	NO	_____
PNEUMONIA	YES	NO	_____	SARCOIDOSIS	YES	NO	_____
BRONCHIECTASIS	YES	NO	_____	NASAL POLYPS	YES	NO	_____
HIATAL HERNIA	YES	NO	_____	TUBERCULOSIS	YES	NO	_____
CYSTIC FIBROSIS	YES	NO	_____	LUNG CANCER	YES	NO	_____
PNEUMOTHORAX	YES	NO	_____				
PULMONARY EMBOLI	YES	NO	_____				
PULMONARY FIBROSIS	YES	NO	_____				

EXPOSURE HISTORY

HAVE YOU WORKED IN OR AROUND ANY OF THE FOLLOWING? (PLEASE EXPLAIN)

ASBESTOS YES NO _____ WELDING YES NO _____
 MINING YES NO _____ METAL DUST YES NO _____

MEDICATIONS

LIST ALL OF YOUR CURRENT MEDICATIONS AND DOSES:

_____	_____
_____	_____
_____	_____

LIST ALL MEDICATION ALLERGIES:

IMUNIZATION STATUS

WHEN DID YOU LAST RECEIVE THE FOLLOWING IMMUNIZATIONS?

PNEUMONIA VACCINE DATE _____

INFLUENZA VACCINE DATE _____

VARRICELLA (CHICKEN POX) DATE _____

PREVIOUS HOPITALIZATIONS/SURGERIES

DATE	WHERE	REASON	PHYSICIAN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RECENT STUDIES

	DATE	LOCATION	RESULTS
TB SKIN TEST	_____	_____	_____
CHEST XRAY	_____	_____	_____
CHEST CAT SCAN	_____	_____	_____
ALLERGY SKIN TEST	_____	_____	_____
PULMONARY FUNCTION TEST	_____	_____	_____

OTHER MEDICAL ILLNESSES

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? (PLS EXPLAIN)

HEART DISEASE **YES NO** _____ **DIABETES** **YES NO** _____

HYPERTENSION **YES NO** _____ **ARTHRITIS** **YES NO** _____

IRREGULAR HEART BEAT **YES NO** _____ **COLITIS** **YES NO** _____

THYROID PROBLEMS **YES NO** _____ **SEIZURES** **YES NO** _____

STOMACH ULCERS **YES NO** _____ **CANCER** **YES NO** _____

ANY OTHER ILLNESSES?

FAMILY HISTORY

HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS? IF SO, WHO?

ASTHMA _____ **LUNG CANCER** _____

EMPHYSEMA _____ **CANCER (OTHER)** _____

ALLERGIES _____ **DIABETES** _____

SIUSITIS _____ **HEART DISEASE** _____

NASAL POLYPS _____ **HYPERTENSION** _____

CYSTIC FIBROSIS _____ **KIDNEY DISEASE** _____

OTHER LUNG DISEASE _____