

Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680

Pulmonary New patient Form

Name _____ Date of Birth _____ / _____ / _____
Last First

Current Medications

(Include all Prescriptions, Supplements, Over the Counter and Herbal Medications)

	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Diagnosis</u> (asthma, depression...etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Allergies / Intolerances

<u>Do You Have Allergies / Intolerances to Medication or Other Substance</u> <input type="checkbox"/> No <input type="checkbox"/> Yes, Please List:	1		3	
	2		4	

Past Medical Problems

(Diabetes, Hypertension, Thyroid....etc)

	<u>Problem</u>	<u>Date / Age Diagnosed</u>		<u>Problem</u>	<u>Date / Age Diagnosed</u>
1			5		
2			6		
3			7		
4			8		

Past Surgeries

	<u>Surgery</u>	<u>Date</u>		<u>Surgery</u>	<u>Date</u>
1			3		
2			4		

Family History

(Please list family medical problems below especially CAD, HTN, DM, respiratory and malignancies)

Father

Alive
Age _____

Deceased
Cause and age of death.

Mother

Alive
Age _____

Deceased
Cause and age of death.

Siblings

Number of
Brothers _____
Sisters _____

Social History

Smoking:

Current Smoker No Yes Packs per Day _____ For How Many Years _____
Previous smoker No Yes Packs per Day _____ For How Many Years _____ Quite Date _____

Alcohol: No Social Yes How much and how often, Type _____

Illicit Drugs:

Marital Status: Single Married Divorced Widowed Engaged

Occupation:

Occupational Exposures (such as asbestoses):

Pets and Birds at home:

Tuberculosis Exposure:

Recent Travel:

Immunization History

Flu: No Yes Date _____ / _____

Pneumonia: No Yes Date _____ / _____

H1N1: No Yes Date _____ / _____

Review of System

Are you currently or regularly experience any of the following symptoms?

(Please check all that apply)

GENERAL

Fatigue [] yes [] no
Fever [] yes [] no
Loss of appetite [] yes [] no
Weight gain [] yes [] no
Weight loss [] yes [] no

SLEEP

Difficulty falling asleep [] yes [] no
Daytime sleepiness [] yes [] no
Breathing cessation during sleep [] yes [] no
Urge to move feet at bedtime [] yes [] no
Snoring [] yes [] no

HEENT

Blurred vision [] yes [] no
Nasal/seasonal allergies [] yes [] no
Change in voice [] yes [] no
Frequent nosebleed [] yes [] no
Hearing loss [] yes [] no
Sinus pain [] yes [] no
Sore throat [] yes [] no

CARDIOLOGY

Supine shortness of breath [] yes [] no
Chest pain [] yes [] no
Palpitations [] yes [] no

RESPIRATORY

Wheezing [] yes [] no
phlegm production [] yes [] no
Cough [] yes [] no
Shortness of breath [] yes [] no

GASTROENTEROLOGY

Abdominal pain [] yes [] no
Blood in stool [] yes [] no
Constipation [] yes [] no
Heartburn [] yes [] no
Diarrhea [] yes [] no

MUSCULOSKELETAL

Back pain [] yes [] no
Joint pain [] yes [] no

DERMATOLOGY

Suspicious moles [] yes [] no
Change in color [] yes [] no
Rash [] yes [] no

ENDOCRINOLOGY

Cold intolerance [] yes [] no
Excessive sweating [] yes [] no
Excessive thirst [] yes [] no
Heat intolerance [] yes [] no

HEMATOLOGY/LYMPH

Easy bruising [] yes [] no
Swollen glands [] yes [] no

NEUROLOGY

Dizziness [] yes [] no
Fainting spells [] yes [] no
Headache [] yes [] no
Memory loss [] yes [] no
Seizures [] yes [] no

PSYCHIATRIC

Anxiety [] yes [] no
Depression [] yes [] no
Hallucinations [] yes [] no

Blood in urine [] yes [] no
Difficulty urinating [] yes [] no
Urinary incontinence [] yes [] no