Patient Name ______________________________ Date ____________

As a new patient of East Tennessee Pulmonary, your first visit could last one to two hours. Please help us make sure your first appointment goes as smoothly and efficiently as possible by taking a few minutes to answer the following questions. Please complete all three pages.

1) What is the reason for your visit today: ______________________________

____

Referring Physician ______________________________

2) Please check if you have a history of any of the following lung problems:

	Yes	No		Yes	No
Asthma	___	___	Frequent colds or infections	___	___
Emphysema	___	___	Frequent cough	___	___
Pneumonia	___	___	Coughing up blood	___	___
Pleurisy	___	___	Wheezing	___	___
Bronchitis	___	___	Breathlessness with activity	___	___
Tuberculosis	___	___	Trouble breathing at night	___	___
Blood clot in lung	___	___	Other	___	___

3) Please check if you have a history of any of the following medical problems:

	Yes	No		Yes	No
Heart murmur	___	___	Stomach ulcers or hiatal hernia	___	___
Heart attack	___	___	Arthritis	___	___
Heart failure	___	___	Bladder or kidney problems	___	___
Irregular heartbeat	___	___	Prostate enlargement	___	___
Angina/chest pain	___	___	Cancer (if yes, where)	___	___
High blood pressure	___	___	Thyroid problems	___	___
Phlebitis or blood clots	___	___	Allergies/hayfever/sinus infections	___	___
Strokes or seizures	___	___	Anxiety or depression	___	___
Diabetes (sugar)	___	___	Hepatitis, HIV, AIDS	___	___

4) Have you ever had surgery? Please list:

	Surgery	Date	Hospital
1.	___	___	___
2.	___	___	___
3.	___	___	___
4.	___	___	___

5) List all medications you are now taking including inhalers and over the counter medicines:

	Medicine	Dose	How often taken
1.	___	___	___
2.	___	___	___
3.	___	___	___
4.	___	___	___
5.	___	___	___
6.	___	___	___
7.	___	___	___
8.	___	___	___
9.	___	___	___
10.	___	___	___

Have you ever been on oxygen at home? Yes_____ No_____

6) Please list any **Allergies** to medications:

Medication	Type of Reaction
1. ______________	______________
2. ______________	______________
3. ______________	______________
4. ______________	______________
5. ______________	______________

7) When was your last Flu Shot? ______________

8) When was your last Pneumonia Vaccine? ______________

9) When was you last Chest X-Ray? ______________

10) When was your last Colonoscopy? ______________

11) Please describe briefly the medical history of your immediate family. If deceased, give age at death and cause.

Father:	age__________	Medical Problems______________
Mother:	age__________	Medical Problems______________
Brother/sister	age__________	Medical Problems______________
Brother/sister	age__________	Medical Problems______________
Son/Daughter	age__________	Medical Problems______________
Son/Daughter	age__________	Medical Problems______________

12) What types of jobs/work have you done?______________

____

13) Have you ever worked with asbestos, beryllium, coal or other possibly harmful materials?

____

14) Where were you born and raised? ______________

How Long have you lived in East Tennessee? ______________

Any overseas travel, military service etc? ______________

15) Have you ever smoked cigarettes __________, cigars __________, pipe __________?

If so: How old were you when you first stated smoking? ______________

How much did/do you smoke per day? ______________

How old were you when you quit smoking? ______________

16) Any alcohol intake? Beer _____ Liquor _____ Wine _____ None _____

How often? Daily _____ Weekly _____ Monthly _____ To excess on occasion _____

Physician Signature______________

PERSONAL HISTORY

Check all that apply

GENERAL

_____ Weight gain in past year
How Much? _______
_____ Weight loss in past year
How Much? _______
_____ Fever
_____ Chills
_____ Night Sweats
_____ Sleeping poorly
_____ Change in appetite

EYES

_____ Glasses or contacts
_____ History of eye surgery
_____ Decreased vision
_____ Pain in eyes

EARS NOSE & THROAT

_____ Earaches or infections
_____ Ringing in ears
_____ Hearing loss
_____ Runny or stuffy nose
_____ Postnasal drainage
_____ Frequent need to clear throat
_____ Frequent sore throat
_____ Sneezing
_____ Frequent hoarseness
_____ Mouth ulcers
_____ Dental problems

HEART AND LUNGS

_____ Chest pain
_____ Pain with deep breath
_____ Heart palpitations
_____ Swelling of feet and ankles
_____ Fluid retention
_____ Smothering at night
_____ Sleeping sitting up or with extra pillows

GASTROINTESTINAL

_____ Frequent Heartburn
_____ Frequent belching or indigestion
_____ Nausea
_____ Vomiting
_____ Difficulty swallowing
_____ Diarrhea
_____ Constipation
_____ Stomach pain
_____ Blood in stool

GENITOURINARY

_____ Painful urination
_____ Bloody urine
_____ Frequent need to urinate
_____ Difficulty starting to urinate

Women Only

_____ Irregular periods
_____ Bleeding between periods
_____ Date of last period
_____ Age at onset of menopause
_____ Pelvic pain
_____ Lump in breast
_____ Nipple discharge

MUSCULOSKELETAL

_____ Painful joints
_____ Swelling of joints
_____ Back pain
_____ Bone pain
_____ Muscle aches

SKIN

_____ Rash
_____ Change in size or color of mole

NEUROLOGIC

_____ Frequent or severe headaches
_____ Dizziness
_____ Fainting spells
_____ Numbness or tingling of hands or feet
_____ Problems with speech
_____ Shakes or tremors

PSYCHIATRIC

_____ Depression
_____ Nervousness
_____ Mood Swings

HEMATOLOGIC LYMPHATIC

_____ Abnormal bleeding
_____ Easy bruising
_____ Swelling of lymph glands

ENDOCRINE

_____ Have you taken any oral steroids (Prednisone, Medrol Delatasone, Decadron) or steroid shots in the past year?
_____ Increased thirst
_____ Increased urination
_____ Intolerance to heat/cold

ALLERGIES

_____ History of allergy testing (skin pricks)
_____ History of positive allergy tests

If so, list ________________

_____ Sinus or breathing problems are worse at certain times or seasons of year

Which seasons ______________

_____ Pets kept inside home
_____ New carpet, curtains, mattress
_____ Feather pillows

Initial if none apply __________