



New Patient Evaluation

Name: _____

Date: _____

Email: _____

Past Medical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Post-Polio Syndrome |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer Type: _____ |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Genetic Disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Alpha -1-antitrypsin deficiency |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Headache Syndrome | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Coronary Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart Rhythm Abnormalities | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Elevated Lipids |
| <input type="checkbox"/> Heart Valve Disorders | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Liver Dysfunction | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: Please List |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sleep Apnea | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> CPAP | _____ |
| <input type="checkbox"/> Autoimmune Disease | CPAP Pressure: _____ | |

Past Surgical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hip/Knee Replacement |
| <input type="checkbox"/> Arterial Bypass | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Lung Surgery |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Organ Transplant |

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Cardiac Valve | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Tonsillectomy | |

Name: _____

Vaccines

- Influenza: Date _____
- H1N1: Date _____
- Pneumococcal: Date _____
- Others: _____

Social

Marital Status: Single Married Divorced Widowed

Living Situation: Alone Spouse Nursing Home Assisted Living

Tobacco Use: Yes No Second hand exposure Yes No

How many packs/day: _____ How many years: _____ What year did you quit? _____

Alcohol Use: Yes No How much: _____

Recreational Drug Use: _____

Pets in home: _____

Hobbies: _____

Recent Travel: Out of State? _____ Out of Country? _____

Known exposure to disease? _____

Occupational History/Exposure

Type of work: _____ Retired: Yes No

Spouse's Occupation: _____

Active TB Exposure: Yes No Last PPD _____ Reactive: _____

Treatment: _____

