New Patient Evaluation

Name:_____ Date:_____

Email:_____

Past Medical History

- ☐ Asthma
- ☐ Allergies
- ☐ COPD/Emphysema
- ☐ Nasal Polyps
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis
- ☐ Pneumonia
- ☐ Sarcoidosis
- ☐ Tuberculosis
- ☐ Congestive Heart Failure
- ☐ Coronary Disease
- ☐ Heart Rhythm Abnormalities
- ☐ Heart Valve Disorders
- ☐ Hypertension
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Autoimmune Disease
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Headache Syndrome
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder
- ☐ Acid Reflux
- ☐ Liver Dysfunction
- ☐ HIV/AIDS
- ☐ Sleep Apnea
- ☐ CPAP

  CPAP Pressure:_____
- ☐ Restless Leg Syndrome
- ☐ Post-Polio Syndrome
- ☐ Kidney Disorder
- ☐ Blood Disorder
- ☐ Cancer Type: _____
- ☐ Genetic Disease
- ☐ Glaucoma
- ☐ Alpha -1-antitrypsin deficiency
- ☐ Obesity
- ☐ Renal Disease
- ☐ Alcoholism
- ☐ Elevated Lipids
- ☐ Systemic lupus erythematosus
- ☐ Alzheimer's disease
- ☐ Other: Please List

  _____

  _____

Past Surgical History

- ☐ Appendectomy
- ☐ Arterial Bypass
- ☐ Heart Bypass
- ☐ Gallbladder
- ☐ Colon Resection
- ☐ Hysterectomy
- ☐ Hip/Knee Replacement
- ☐ Lung Surgery
- ☐ Organ Transplant

☐ Cardiac Valve
☐ Carotid Endarterectomy
☐ C-Section
☐ Pacemaker
☐ Defibrillator
☐ Hernia Repair
☐ Tonsillectomy
☐ Kidney
☐ Spleenectomy
☐ Other: _____

Name: _____

Vaccines

☐ Influenza: Date _____

☐ H1N1: Date _____

☐ Pneumococcal: Date _____

☐ Others: _____

Social

Marital Status: Single Married Divorced Widowd

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:_____

Asbestos exposure: Yes No If yes, when & where:_____

Fumes/Chemicals/Toxins Exposure:_____

Name: _____

Sleep Patterns

Changes in sleep patterns:	____ No _____ Yes
Average number of hours of sleep per night:	_____
Trouble falling asleep:	____ No _____ Yes
Difficulty staying asleep:	____ No _____ Yes
Frequent waking episodes at night	____ No _____ Yes
Disrupted breathing, gasping, gagging or choking for air during sleep:	____ No _____ Yes

Lifestyle

Activity Level: _____Moderate ____ Sedentary Vigorous _____

Health club member:_____ Now ____ Previously Never _____

Type of exercise: _____

Exercise frequency: _____

Hours/week: _____

Hobbies/Activities: _____

Current Diet: _____

Animals in the home: No_____ Yes _____ Type _____

Pharmacy

Please list each pharmacy used

Pharmacy Name: Pharmacy Location:

_____ _____

Primary Care Physician

Family Physician

Physician Name _____ City _____

_____ _____

Name: _____

Family History

Father's History:_____

Mother's History:_____

Siblings:_____

Children:_____

Has anyone in your family had lung disease? Yes No

If so, what type?_____

Medications

Please list all prescriptions & over the counter

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies

Please list all allergies

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____