Central Arkansas Lung Intake

Name______________________________ DOB_______/________/________ Date_______/_______/________

Primary Physician ____________________ Referring Physician ________________ Pharmacy ____________________

What symptoms brought you to our clinic? ____

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How long have you experienced these symptoms? ____

Do you see any other specialty physicians? (Cardiologist, Oncologist, etc.) ____

Have you recently been hospitalized? ___________ When:_____________ Where: ____

Have you recently been in Urgent Care? _________ When:_____________ Where:____

Have you recently had any of the following: When: Where:

Chest X Ray____________________ PET ___________________________ Echocardiogram ___________________

Chest CT______________________ VQ Lung Scan ___________________ Heart Cath ________________________

Lab work______________________ Lung Biopsy ____________________ Other ____________________________

When was your last Flu vaccine? ______________ Pneumonia Vaccine?_______________ COVID vaccine __________________

Have you ever smoked in your lifetime: Never _________________ Former _________________ Current _________________

Packs per day:__________ Years: __________________ Quit date: _______________

Do you currently: Drink alcohol: _________ How much: ___________ How often:_________

Do you currently: Drink caffeine: ________ How much: ___________ How often:_________

Do you currently: Exercise: ____________ What type: ___________ How often:_________

Are you currently using any respiratory equipment? CPAP/BiPAP _______ Trilogy_______ Oxygen _______ Other ____________

Are you currently taking any respiratory medications? (Inhalers)____

Have any of your current or previous occupations exposed you to the following:

☐Asbestos ☐Ammonia ☐Agent orange ☐Chemical/Toxin ☐Chemical fumes/gases ☐Coal dust ☐Fiberglass

☐Mold ☐Radiation ☐Silica/dust ☐Tobacco exposure ☐ Soldering/welding ☐Wood burning stove

Medications : ____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________ ____________________

Medication Allergies: ____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________ ____________________