

Ventura Pulmonary and Critical Care Medical Group

Today's date: _____

Your name: _____

Age: _____

Referring Doctor: _____

The reason for your visit at this office: _____

Recently, have you had any of the following symptoms? (Check any that apply)

- ___ Cough
- ___ Sputum
- ___ Bloody sputum
- ___ Shortness of breath
- ___ Wheezing
- ___ Chest pain

Do you currently have or have you ever had any of the following medical problems (Check any that apply)?

- | | |
|--------------------------------------|-----------------------------|
| ___ Asthma | ___ Atrial fibrillation |
| ___ Emphysema | ___ Arthritis |
| ___ COPD | ___ Thyroid disease |
| ___ Tuberculosis | ___ Sinus infections |
| ___ Valley Fever | ___ Seizures |
| ___ Blood clots in your leg or lungs | ___ Migraine headache |
| ___ Pneumonia | ___ Stroke |
| ___ Pulmonary Fibrosis | ___ Kidney disease |
| ___ Congestive heart failure | ___ Liver disease |
| ___ High blood pressure | ___ Glaucoma |
| ___ Diabetes | List other medical problems |
| ___ Heart attack | _____ |
| ___ Coronary artery disease | _____ |
| ___ Rheumatic Fever | _____ |
| ___ Heart murmur | _____ |

List allergies to medications:

List all operations/surgeries that you have had:

Turn this page over and complete the second page of the questionnaire

Do you smoke? Y/N (circle one) Did you used to smoke? Y/N (circle one);
List packs per day and # of years you have smoked _____

How much beer, wine, or spirits do you drink daily? _____
Please discuss any illicit drug use with the doctor today.

List all current medications (including inhalers, nasal sprays, and over the counter or home remedies) and their dose and frequency of administration:

When was your last Flu vaccine? _____ When was your last pneumonia vaccine? _____

Place of birth: _____

What is/was your occupation? Any military service?

List any job or hobby exposures to dusts, fumes, or vapors:

List any pets that you have: _____

Do or did either of your parents, brothers, sisters, or children have respiratory diseases?

Please circle any of the following symptoms that you have had *recently*:

- | | |
|-------------------------------|--|
| <u>Constitutional:</u> | Fever, night sweats, weight gain, weight loss, fatigue |
| <u>Eyes:</u> | Eye strain, pain, double vision, light sensitivity, excessive tearing, corrective lenses, blurring |
| <u>Ear nose and throat:</u> | Ear discharge, deafness, ringing in ears, dizziness, bloody nose, nasal discharge, nasal obstruction, postnasal drip, sinus pain, dental problems, hoarseness, difficulty swallowing, snoring, sleep apnea |
| <u>Cardiovascular:</u> | Chest pain, palpitations, rapid heartbeat, faintness, leg swelling |
| <u>Gastrointestinal:</u> | Nausea, vomiting, vomiting blood, blood in bowel movement, abdominal pain, jaundice, constipation, diarrhea, heartburn |
| <u>Genitourinary:</u> | Painful urination, blood in the urine, night time urination, frequent urination, discharge, incontinence |
| <u>Musculoskeletal:</u> | Backache, joint pain, leg cramps, stiffness |
| <u>Integumentary:</u> | Rash, skin bumps, itching, dryness, hair loss |
| <u>Neurological:</u> | Weakness, loss of coordination, seizures, tremors, headaches, tingling in the feet or hands, confusion, sleepiness |
| <u>Psychiatric:</u> | Memory loss, personality change, insomnia |
| <u>Endocrine:</u> | Intolerance of heat or cold, excess thirst |
| <u>Hematologic/Lymphatic:</u> | Anemia, bruising or bleeding tendency |
| <u>Allergic/immunologic:</u> | Environmental/food sensitivities, susceptibility to infection |