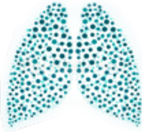

Ventura Pulmonary and Critical Care Medical Group

Today's Date:____________________

Your Name:___________________________________ Date of Birth_______________

Doctor who sent you here:____

Your primary care 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
___ Emphysema
___ COPD
___ Tuberculosis
___ Valley Fever
___ Blood clots in your leg or lungs
___ Pneumonia
___ Pulmonary Fibrosis
___ Congestive heart failure
___ High blood pressure
___ Diabetes
___ Heart attack
___ Coronary artery disease
___ Rheumatic Fever
___ Heart murmur

___ Atrial fibrillation
___ Arthritis
___ Thyroid disease
___ Sinus infections
___ Seizures
___ Sleep Apnea
___ Stroke
___ Kidney disease
___ Liver disease
___ Glaucoma

List other medical problems

____
____
____
____

List allergies to medications:

____
____

List all operations/surgeries that you have had:

____
____
____
____

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*:

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