Pulmonary Group
of Central Florida, LLC

Patient Name: _____ Date of Appointment: _____

Referring Physician: _____

Primary Physician:_____

Patient's Chief Complaint: _____

_____

Are you currently working? If so, please state occupation: _____

Exposure to chemicals? __ Yes __No. If yes, please list: _____

Any pets at home/type of pet?_____

Marital Status (Circle One): Married Single Widowed Divorced

Smoking Now? __ Yes __ No. Alcohol: Type & Amount: _____

Packs Daily: _____ Ever Smoke: __ Yes __No. How long? _____

When did you quit? _____ Sleep pattern (hrs. per night): _____

MEDICATION LIST - Include prescription and over the counter medications.

MEDICATION NAME	STRENGTH	TIMES TAKEN PER DAY

MEDICATION ALLERGIES: _____

_____

OTHER ALLERGIES: _____

_____

PAST MEDICAL HISTORY – Do you have or have you ever had the following:

	Yes	No		Yes	No
Measles	___	___	GERD (reflux)	___	___
Mumps	___	___	Hiatal Hernia	___	___
Whooping Cough	___	___	Anemia(type)	___	___
Scarlet Fever	___	___	Kidney Disease	___	___
Rheumatic Fever	___	___	Ulcer	___	___
Poliomyelitis	___	___	Hypothyroidism	___	___
Tuberculosis	___	___	Osteoarthritis	___	___
Pneumonia	___	___	Rheumatoid Arthritis	___	___
Asthma	___	___	Cataracts	___	___
Bronchitis	___	___	Glaucoma	___	___
Emphysema	___	___	Hepatitis	___	___
Hay fever/Sinusitis	___	___	Cancer	___	___
Hypertension	___	___	Type of Cancer	_____	
Coronary Disease	___	___	Other:	_____	
Diabetes (type)	___	___		_____	

SURGERIES – Please list type of surgery and your age at time of surgery:

_____

_____

_____

_____

FAMILY HISTORY:

Father: If Living Age and Health status: _____

If Deceased Age at death and cause of death: _____

Mother: If Living Age and Health Status: _____

If Deceased Age at death and cause of death: _____

REVIEW OF SYSTEMS (Circle or checkmark any complaints within last six months.)

APPETITE: Good Fair Poor

RECENT WEIGHT CHANGE: Loss of _____ pounds. Gain of _____ pounds.

FEVER: ___Yes. ___ No.

CHILLS: ___ Yes. ___ No.

DIZZINESS: ___ Yes. ___ No.

HEADACHES: ___ Yes. ___ No. If yes circle type: Sinus Tension Migraine

EYES: Circle complaint: Double Vision Blurred Vision Other: _____

EARS, NOSE, & THROAT: Circle complaint: Nasal congestion Nasal Drainage Sore Throat

Hoarseness Other: _____

RESPIRTORY: Shortness of breath: ___ Yes. ___ No.

If short of breath, circle when:	Sitting	Standing	Bending	Exertion
Wheezing:	___ Yes.	___ No.		
Cough:	___ Yes.	___ No.		
Sputum production:	___ Yes.	___ No.	Color of sputum: _____	
Blood in sputum:	___ Yes.	___ No.	If yes, How long: _____	

CARDIOVASCULAR- Circle complaint: Chest pain Palpitations Other: _____

GASTROINTESETINAL- Circle complaint: Abdominal pain Nausea Vomiting Diarrhea

Bloody Stools Other: _____

GENITOURNEY- Circle complaint: Urinary frequency Slow urinary stream

Blood in urine Pain with urination

MUSCULOSKELETAL- Circle complaint: Osteoarthritis Rheumatoid arthritis Back pain Neck pain

Shoulder pain Numbness/Where? Other: _____

NEUROPSYCHIATRIC- Circle complaint: Anxiety Depression Insomnia Snoring Restless sleep

Daytime sleepiness Other: _____

Office use only:

Temp: _____ Blood Pressure: _____ Pulse: _____ Resp: _____

Weight: _____ Height: _____ Pulse oximetry: _____