Pulmonary & Critical Care Associates, P.C.

MEDICAL INFORMATION SHEET

Today's Date	

PATIENT INFORMATION (Please print)	
Name:	
Date of Birth:	**Place of Birth:**

CHIEF COMPLAINT (What brings you into the office today)	
Chief Complaint:	**Duration of symptoms:**

IMMUNIZATIONS (Record the date/year of last vaccine, if known)	
Flu Vaccine:	**Pneumonia Vaccine:**

PAST MEDICAL HISTORY: (Please circle any of the conditions that you have now or have had in the past)

Acid Reflux	Heart Attack	Obesity	Seizures	Other: (please specify)
Arthritis	High Cholesterol	Peptic Ulcer Disease	Sinusitis	
Asthma	Hypertension	Pleural Effusion	Sleep Apnea	
Cirrhosis	Hypothyroidism	Pneumonia	Stroke	
Congestive Heart Failure	Insomnia	Pulmonary Embolism	Tuberculosis	
COPD	Kidney Failure	Pulmonary Fibrosis	Cancer (please specify):	
Diabetes	Lung Cancer	Sarcoidosis		
Deep Vein Thrombosis (DVT)	Narcolepsy	Seasonal Allergy		

PAST SURGICAL HISTORY: (Please circle all that apply, specify where necessary and indicate year)

Appendectomy (appendix)	Cholecystectomy (gallbladder)	Ovaries (*specify*)	Tonsils
Bladder (*specify*)	Heart (*specify*)	Pacemaker (*specify*)	Other:
Bowels (*specify*)	Hysterectomy	Prostate (*specify*)	
Cesarean Section	Lung (*specify*)	Sinus (*specify*)	

ALLERGIES:

ALLERGIES to MEDICATION (Describe Reaction)	**ALLERGIES to FOOD/OTHER** (Describe Reaction)

SOCIAL HISTORY: (Please note answers to all questions are part of your permanent medical record)

Cigarette Smoking		
Have you ever smoked? Yes No	If yes, for how many years?	How many packs per day?
When did you quit?	What things (nicotine gum, patch, etc.) have you tried to help you quit?	

Name:	DOB:

Illicit Drug Use		
Have you ever used illegal drugs? Yes No	What did you use?	When was the last time?
Alcohol Use		
Do you drink alcohol? Yes No	How much?	How often?
Caffeine Use		
How often do you consume caffeine? Daily Rarely Never	What sources? (i.e. soda, coffee, tea, etc.)	How much?
General History		
Do you have pets at home? If yes, what pets?		

FAMILY MEDICAL HISTORY: (Please list your immediate family members (parents, grandparents, siblings, children), their relationship to you, along with their health status (living or deceased) and any related medical conditions (especially pulmonary conditions such as emphysema, asthma and lung cancer)

Family Member Name	Relation	Health Status	Medical Conditions
		Living / Deceased	
		Living / Deceased	
		Living / Deceased	

OCCUPATIONAL HISTORY: (Please list your last two jobs/occupations and include any occupational exposure to solvents, heavy metals, asbestos, organic or inorganic dusts or any other materials which you believe may be contributing to your lung status)

Job Description	Exposures

MEDICATIONS: List all medicines you are currently taking, prescription, over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin). If additional space is needed, please continue on back.

NAME OF MEDICATION / DOSE	DIRECTIONS:	PRESCRIBING DOCTOR: