PULMONARY & CRITICAL CARE ASSOCIATES

MEDICAL INFORMATION SHEET

(Please Print)

Today's date:	
PATIENT INFORMATION	
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 check any of the conditions that you have now or have had in the past)			
Acid Reflux	Arthritis	Asthma	Cirrhosis
Congestive Heart Failure	COPD	Diabetes	Deep Vein Thrombosis (DVT)
Heart Attack	High Cholesterol	Hypertension	Hypothyroidism
Insomnia	Kidney Failure	Lung Cancer	Narcolepsy
Obesity	Peptic Ulcer Disease	Pleural Effusion	Pneumonia
Pulmonary Embolism	Pulmonary Fibrosis	Sarcoidosis	Seasonal Allergy
Seizures	Sinusitis	Sleep Apnea	Stroke
Tuberculosis	Cancer (please specify):	Other (please specify):	

PAST SURGICAL HISTORY			
(Please check all that apply, specify where necessary and indicate year)			
Appendectomy (appendix)	Bladder (specify)	Bowels (specify)	Cesarean Section
Cholecystectomy (gallbladder)	Heart (specify)	Hysterectomy	Lung (specify)
Ovaries (specify)	Pacemaker (specify)	Prostate (specify)	Sinus (specify)
Tonsils	Other		

ALLERGIES	
Allergies to Medication (Describe reaction)	**Allergies to Food/Other (Describe reaction)**

Name:	Date of Birth:

SOCIAL HISTORY

(Please note answers to questions are part of your permanent medical record)

Cigarette Smoking:		
Have you ever smoke?	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?	
Illicit Drug Use:		
Have you ever used illegal drugs?	What did you use?	When was the last time?
Alcohol Use:		
Do you drink alcohol?	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 contribution to your lung status.

Job Description	Exposures

MEDICATIONS

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

Name of Medication / Dose	Directions	Prescribing Doctor