Rex Pulmonary Specialists

VISIT INFO

Primary Care Physician _____
Referring Physician_____
Who else should get your records from this visit_____
What can we do for you today?____
_____

ALLERGIES

List all drug allergies
Drug_____Reaction_____
Drug_____Reaction_____
Drug_____Reaction_____
_List any other allergies (e.g. Seasonal allergies, foods, latex)_____
_____

PHARMACIES

Local Pharmacy _____
Mail Order pharmacy_____
Preferred pharmacy_____

MEDICATIONS

List all medications. Include medications that do not require a prescription.

Drug	Strength	Frequency
_____	____mg	_____
_____	____mg	_____
_____	____mg	_____
_____	____mg	_____
_____	____mg	_____
_____	____mg	_____
_____	____mg	_____
_____	____mg	_____

MEDICAL HISTORY

Circle all conditions you have or had

-ABPA -nasal allergies
-alpha 1 deficiency
-anemia -asthma
-Bronchiectasis -Tuberculosis
-Chronic Bronchitis
-Sinus Disease - Diabetes
-Coronary Artery Disease
-C.F. -Emphysema
-Deep Vein Thrombosis
-Heart failure (systolic or diastolic)
-GERD -HIV/AIDS
-High blood pressure
- Pulmonary Fibrosis
-Interstitial lung disease
-Lung Cancer -Lung Nodule
-Lupus -pneumonia
-Pulmonary Hypertension
-Pleural effusion -Polymyositis
-Scleroderma -Sjogren's Synd
-Rheumatoid Arthritis
-Sarcoidosis - Sleep apnea

SURGICAL HISTORY

List any surgeries you have had
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____

FAMILY MEDICAL HISTORY

Relative	Alive?	Medical Problems
Mother	Y/N	_____
Father	Y/N	_____
Bro/Sis	Y/N	_____
Bro/Sis	Y/N	_____
Bro/Sis	Y/N	_____
Child	Y/N	_____

Grandparents_____
_____

SOCIAL HISTORY

Tobacco
Do you currently smoke? Y/N
Have you ever smoked? Y/N
Years smoked _____
Packs/day ___
When did you quit?_____

Alcohol
Do you drink alcohol Y/N
Alcoholic beverages/ week _____

Work
Have you ever worked in an environment considered dangerous to your health (e.g. silica exposure in a rock quarry?) Y/N
Explain_____

Exposures
Tuberculosis Y/N
Have you ever had a positive TB skin test (PPD)? Y/N
Asbestos Y/N
Indoor birds Y/N
Home hot tub Y/N
List travel outside of NC _____
_____
_____

Immunizations

Have you ever received
1) pneumonia vaccine (Pneumovax)? Y/N
When?_____
2) Flu vaccine? Y/N
When?_____

CARE EVERYWHERE

List all hospitalizations (except for pregnancies and surgeries):

Reason		Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Should we get records from another doctor's office or hospital? Y/N
List which offices or hospitals_____
_____

REVIEW OF SYSTEMS

Circle all symptoms you are having or recently have experienced:

Weight loss Fever/chills
Weakness Fatigue
Visual changes Hoarseness
Sneezing Sinus congestion
Bloody nose sore throat
Rashes Itching
Chest pain Palpitations
Shortness of breath:
At rest sleeping
With exertion wakes you at night
Only when allergies/asthma flare
Relieved with inhaler(s)
Cough Wheeze
Coughing up blood (hemoptysis)
Nausea Vomiting
Diarrhea Abdominal Pain
Burning with urination
Headache Dizziness
Weaknesss Numbness
Muscle Pain Joint pain
Anemia Bleeding easily
Bruising easily
Enlarged lymph nodes (glands)
Depression Anxiety
Heat/cold intolerance
Asthma Hives
Eczema Seasonal Allergies
Snoring loudly Morning Headache
Daytime sleepiness

OFFICE USE ONLY:
MU?
PQRS?