NOVA

PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES LLC

Patient Name: _____DOB: _____Date of Service: _____.

Section 1 - Past Medical History

What other Medical Diseases do you have (circle)

High Blood Pressure
High Cholesterol
Diabetes
Heart Disease
Heart attack
Atrial Fibrillation
Asthma
COPD
Sarcoidosis
Lung cancer
Obstructive Sleep Apnea
Cancer
Allergic Rhinitis
Thyroid disorder
Liver Disease, Cirrhosis
GERD or Heartburn
Anemia
Chronic kidney disease
Depression
Anxiety
Osteoporosis
Stroke or TIA
Multiple Sclerosis
Others – List:

Any surgeries -

Section 2 – Social History and Allergies

Have you ever smoked cigarettes? Yes No
If yes: Do you smoke now? Yes No
If so: At what age did you start smoking? _____
How many packs a day do you smoke/d? _____
At what age did you stop smoking? _____

Are you working now? Yes No
What is your occupation?
Have you ever been exposed to asbestos or dust or strong fumes at work? Yes No (describe)

Do you keep animals at home? Yes No
If any, what kind?

Do you drink alcohol? Yes No
Approximately how many drinks of alcohol do you drink in a day or week? _____

Vaccination History –
Last Influenza vaccine ? -
Last Pneumonia Vaccine ? –

Allergies – Environment and Medications:

Section 3 – Family History

What diseases runs in your family? (Circle, describe and indicate relative/s)
COPD or Emphysema
Asthma
Other Lung Disease
Lung Cancer
Pulmonary Embolism
DVT
Sarcoidosis
Scleroderma
Lupus
Heart Disease
Stroke
Diabetes
Hypertension
Cancer
Others (list)

Section 4 – Review of Systems

Have you experienced any of these over the past 3 months ?
Shortness of Breath
Cough
Wheezing
Coughing up blood
Nose or sinus problems including hay fever
Nasal congestion
Post-nasal drip
Snoring
Sleepiness in the daytime
Fever, sweats, chills
Chest pain
Irregular or rapid heart beats
Heartburns/Indigestion
Nausea or Vomiting
Abdominal pain
Constipation or Diarrhea
Difficulty swallowing or regurgitation
Ear Aches
Eye irritation or dry eyes
Double vision
Weight loss more than 5lbs
Swelling at ankles
Fingers turn white and painful in cold
Joint pains or muscle aches
Back or neck pain
Headaches
Unusual dizziness, faintness or loss of consciousness
Numbness or weakness of part of your body
Painful or frequent urination
Rash
Seizures
Anxiety
Depression
Easy bleeding or bruising
Others – Please list