PENN JERSEY PULMONARY ASSOCIATES

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.

NAME______________________ Birth Date______________ Today's Date:__________

Referred by Dr.______________________ Primary Care Dr. ______________________

Gender: M___ F___ Height: _________ Weight:_________

Reason for Visit today: ______________________________________

Main symptom: ______________________________________

How long have you had it?: ______________________________

PAST MEDICAL HISTORY

Have you ever had any of these Illness or Conditions?

(If yes, place √ mark in the □)

□ Asthma □ Bronchitis □ Emphysema □ Pneumonia □ Tuberculosis □ Sarcoidosis
□ Bronchiectasis □ Seasonal Allergy □ Pneumothorax □ Hiatal Hernia □ Sinusitis □ Cystic Fibrosis
□ Gastroesophageal Reflux □ Bleeding Tendency □ Kidney Disease □ Stroke □ Deep Vein Thrombosis
□ High Blood Pressure □ Diabetes □ Heart Disease (Angina Arrhythmias or a heart attack)
□ Pulmonary Embolism □ Rheumatic Fever □ Glaucoma □ Sleep Apnea □ Lung Cancer
□ Other Cancer ______________ type: ___________

- LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED with dates:

____
____

- PREVIOUS OPERATIONS (Dates, Hospitals and Name of surgeon)

____
____
____

LIST ANY ** ALLERGY OR SENSITIVITY TO MEDICATIONS OR OTHER SUBSTANCES, AND TYPE OF REACTION THAT OCCURRED:**

____
____

List the Medications you are presently taking: (or attach your list)

1.________________ 5.________________
2.________________ 6.________________
3.________________ 7.________________
4.________________ 8.________________

SOCIAL HISTORY

-Do you speak and understand English? _________(yes or no)
(If NO, did someone accompany you to interpret?)________ (yes or no)

-Do you have any religious beliefs that may influence how we treat you? ____ (Yes or no)
If yes, please explain: ______________________________________

Name______________________________**Birth Date:** ______________**Today's Date**__________

Your Occupation:______________________________How long?______________

- Have you ever had a job which exposed you to:

☐ DUSTS ☐ FUMES ☐ ASBESTOS ☐ SANDBLASTING ☐ CHEMICALS ☐ OTHERS?

Please explain amount and duration of exposure:

____

____

Are married: _____(Year married) : ______________Education (highest level attained)__________

What types of hobbies or recreational activities do you have: ______________________________

____

Have you live or traveled outside the U.S. and Canada? ☐ yes ☐ no

(if yes where and when? : ____).

Do you drink caffeinated beverages? ☐ yes ☐ no What Kind?______________

Daily amount: ______________

Do you have any pets? ☐ yes ☐ no ____Dog(s) ____ Cat(s) ____ Bird(s) Other ______

-Are you currently a smoker?______(yes or no) Tobacco type:______________

-Are you an ex-smoker______(yes or no) (If yes when did you quit?______)

-How many packs per day?________ How many years did you smoke?________

-Do you have any second hand smoke exposure?______

-Do you drink alcohol on a daily basis? ____(yes or no) type?_____ Weekly amt:_________ How long?:______________

- Do you use illegal drugs? ______ (yes or no) If yes, please explain______________

FAMILY HISTORY

ALIVE .... DECEASED ...	***Father*** ☐ ***Age*** ______ ☐ ***Age*** ______	***Present health or cause of death***	***Mother*** ☐ ***Age*** ______ ☐ ***Age*** ______	***Present health Or cause of death***	***Spouse*** ☐ ***Age*** ___ ☐ ***Age*** ___	***Present Health or Cause of death***

BROTHERS	# Alive	HEALTH	# Deceased	Cause of Death
SISTERS	#Alive	HEALTH	#Deceased	Cause of Death
CHILDREN	#Alive	Ages and Health	#Deceased	Ages and Cause of Death

CHECK THE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** AND SPECIFY RELATION

(M = mother; F = father; B = brothers; S = sisters; A = aunt; U = uncle; GMF = grandmother on father's side; etc

☐ Asthma______
☐ Cystic Fibrosis______
☐ Alpha 1 antitrypsin deficiency ____
☐ Sarcoidosis_______
☐ Interstititl Lung Disease____
☐ Diabetes _____

☐ Breast Cancer____
☐ Colon Cancer_____
☐ Bleeding Tendency____
☐ Kidney Disease______
☐ Heart Disease ______

☐ Stroke ______
☐High Blood pressure _____
☐ Nervous Illness_____
☐Allergy _________
☐Other ______________

Name________________________Birth Date________________Today's Date:__________

REVIEW OF SYSTEMS

HAVE YOU HAD ANY OF THE FOLLOWING SIGNS OR SYMPTOMS

Constitutional
□ Weight loss □ Excess Fatigue □ Fever
□ Chills □ Night sweats □ Weakness
□ Anorexia

Eyes
□ Glasses/contacts □ Vision Changes
□ Double vision □ Blurred Vision
□ Pain □ Discharge □ Excessive tearing

ENT/Mouth
□ Earache □ Tinnitus □ Discharge
□ Hearing loss □ Popping □ Post-nasal drip
□ Hoarseness □ Bad Breath □ Swelling
□ Sore Throat □ Bleeding gums
□ Toothache □ Oral lesions □ Dentures

Cardiovascular
□ Chest pains □ Angina □ Palpitations
□ Murmur □ Claudication
□ Shortness of breath after going to sleep

Respiratory
□ Cough □ Sputum Production
□ Coughing up Blood □ Chest pain
□ Wheezing □ Sinus Congestion □ Asthma
□ Frequent respiratory infections
□ Stopping Breathing at night
□ Daytime sleepiness □ unrestful sleep
□ Morning Headaches □ Obstructive sleep apnea

Blood / Lymphatics
□ Easy Bruising □ Anemia □ Bleeding
□ Swollen/ painful lymph nodes

Neurologic
□ Numbness or Tingling □ Tremor
□ Fainting □ Headaches
□ Muscle Weakness □Paralysis
□ Dizziness □ Seizures
□ memory loss □ Strokes
□ Unconsciousness

Gastrointestinal
□ Heartburn □ Nausea or Vomiting
□ Diarrhea □ Constipation
□ Blood in stool □ Blood in vomit
□ Food Intolerance □ stomach ulcers
□ Laxative use □ Gas/Indigestion
□ Herpatitis □ Hernia □ Rectal Bleed/pain
□ Polyps □ Colitis □ Diverticulitis (-osis)
□ Abdominal Pain □ Trouble Swallowing

Genito-urinary
□ Burning urination
□ Frequency of urination
□ Urination after going to sleep
□ Urgency or urination □ Dribbling
□ Blood in urine □ Infections

Muscloskeletal
□ Joint pain □ Varicose veins
□ Claudication □ Back pain □ Swelling
□ Joint Stiffness

Endocrine
□ Hot Flashes □ Hair loss
□ Temp Intolerance □ Goiter □ Diabetes

Skin and / or Breast
□ Itching □ Rash □ Lesions
□ Color changes □ Dermatitis □ Eczema
□ Breast lumps, pain, bleeding, or discharge

Allergy / Immunology
□ AIDS □ Chronic steroids
□ Recurrent Infections □ Allergies
□ Hives

Psychiatric
□ Depression □ Anxiety
□ Insomnia □ Sexual problems
□ Therapy □ Nightmares
□ Nervous Illness

Would you like a copy of our report to go to any other doctors (list):

____

Do you have a Living Will?______________________________

Patient's Signature: ______________________________ Date: ____________

Reviewed by: ______________________________ M.D. Date: ____________