KENT PULMONARY ASSOCIATES

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Patient Name: _____ DOB: _____ Date of Service: _____

Section 1: Past Medical History

Other Medical Disease (circle and describe)
High Blood Pressure

High Cholesterol

Diabetes

Heart Disease

Drug Allergies

Other (list)

Last Influenza vaccine?

Last Pneumonia vaccine?

Section 2: Your Social History

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 (described)

Have you ever smoked cigarettes? Yes No
If yes: Do you smoke now? Yes No
If so: At what age did you start smoking? _____
At what age did you stop smoking? _____

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

Approximately how many drinks of alcohol do you drink in a day or week? _____

Section 3: Your Family History

(Circle, describe and indicate relative/s)
What disease runs in your family?

Allergies

Asthma

Other Lung Disease

Heart Disease

Cancer

Others (list)

Previous Surgery:
Lung surgery (year)

Heart Surgery (year)

Others (list)

Section 4: Review of Symptoms other than breathing problem

Abdominal Pain Shortness of Breath
Fever, sweats, chills
Nausea or Vomiting
Difficult, painful or frequent urination
Irregular menstrual periods
Weight loss more than 5 lbs
Headaches
Swelling at the ankles
Ear Aches
Joint pains or muscle aches
Eye irritation
Fingers turn white and painful in cold
Blurred or double vision
Nose or sinus problems including hay fever
Back or neck pain
Snoring
Breast Discomfort
Chest Pain
Irregular or rapid heart beats
Heartburns/Indigestion
Difficulty swallowing or regurgitation
Dry eyes or dry mouth
Automobile accident
Unusual dizziness, faintness or loss of consciousness
Numbness or weakness of part of your body
Anxiety
Depression
Others