New Patient History Evaluation

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Referring Physician: _____ City: _____

Primary Physician: _____ City: _____

Chief Complaint/Primary Reason for evaluation:

- □ COPD
- □ Asthma
- □ Cystic fibrosis
- □ Sleep apnea
- □ Food Allergy
- □ Seasonal Allergies
- □ Bronchitis
- □ Shortness of breath/dyspnea
- □ Sarcoid
- □ Hemoptysis (coughing blood)
- □ Hives
- □ Immune Deficiency
- □ Cough
- □ Wheezing
- □ Pneumonia
- □ Lung cancer
- □ Allergic Reactions
- □ Other: _____

Are there other concerns that you would like to discuss with your provider today? _____

_____

_____

_____

_____

Have you ever been hospitalized for the condition you are being seen for today?

When? : _____

Where? : _____

History of Present Illness (Details of your illness):

Tobacco Assessment

Smoking status: □ Every day smoker □ Never smoked
□ Former smoker □ Passive Smoker (exposure to others who smoke)

Type: □ Cigarettes Packs/day: _____
□ Cigars
□ Pipe
Years: _____ Date quit: _____

Smokeless tobacco: □ Current use Type: □ Snuff
□ Former use □ Chew
□ Never Date quit: _____

Ready to quit: □ Yes □ No

Allergy History

Please list all medications and other substances for which you are allergic or have caused an adverse reaction.

Medication/Substance	Reaction*

*Allergic/Adverse Reactions Types:

□ Abdominal pain
□ Anaphylaxis
□ Anxiety
□ Itching
□ Muscle pain
□ Fainting
□ Diarrhea
□ Dizziness
□ Hallucination
□ Headache
□ Hives
□ Swelling
□ Cough/shortness of breath
□ Nausea/Vomiting __
□ Palpitations ("racing heart")
□ Rash

Check all that you are allergic to, **when** the allergy occurs (spring, summer, fall, winter) and what kind of reaction you have?

□ Dust: _____
□ Pollen: _____
□ Mold/Mildew: _____
□ Animals: _____

□ Foods (especially seafood): _____
Other: _____

Have you ever had allergy testing? □ Yes □ No
Allergy shots? □ Yes □ No
Have you ever had a chest x-ray? □ Yes □ No
Have you ever had a breathing test? □ Yes □ No
Have you ever had a sinus evaluation? □ Yes □ No
Doctor: _____ Date: _____
Have you ever had sinus surgery? □ Yes □ No
Doctor: _____ Date: _____

Current Medications: (Please list all medications you are currently taking including herbal medicines, vitamins and/or over the counter medicine)

Medication	Dose	Route	How Often	Reason	Start Date	End Date

Oxygen:

Do you use oxygen: □ Yes □ No When? □ With activity □ Night □ At rest

How many liters/minute? _____ How many hours per day? _____

Past Medical History: (List your current/past health problems)

- □ Seasonal Allergies
- □ Asthma
- □ Chronic Cough
- □ Cystic fibrosis
- □ Eczema
- □ Heart attack or coronary artery disease
- □ Pulmonary embolism
- □ Esophageal reflux or GERD
- □ Pulmonary fibrosis
- □ Pulmonary hypertension
- □ Hives
- □ Chronic bronchitis
- □ Congestive heart failure
- □ Hypertension
- □ Diabetes
- □ Cancer type:_____
- □ COPD
- □ Stroke
- □ Pneumonia
- □ High cholesterol
- □ Arthritis
- □ Frequent Infections, where: _____
- □ Emphysema
- □ Atrial fibrillation

Please provide other current/past health problems: _____

_____

_____

_____

Previous Surgical History **Year**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Family History: (Please indicate if a member of your family has asthma, bronchitis, arthritis, diabetes, tuberculosis, stroke or cancer)

	Age	Alive/Deceased	Health Problems	Cause of Death
Mother	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Brother:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Alcohol History (please include # of drinks per week)

- □ Cans of beer _____
- □ Glasses of wine _____
- □ Shots of liquor _____
- □ Drinks containing more than 5 oz of alcohol _____

Has drinking ever been a problem? _____

Did you quit and when? _____

Drug use

Have you ever used? □ Marijuana □ Cocaine
□ Other illicit drugs (please specify): _____

Social History

Are you married? □ Yes □ No How many years? _____
Number of children? _____ Are they healthy? _____

Where do you work/what do you do? _____

What other jobs have you had in your lifetime? _____
_____

Have you **ever** (as a child or adult) been exposed to any of the following: (please check all that apply)

□ Asbestos □ Fumes
□ Dust □ Coal dust
□ Cotton dust □ Silica
□ Animals □ Birds (types) _____
How long? _____

Do you have any pets? _____ (inside/outside) Type: _____

Any unusual travel experiences? _____
Where have you lived? _____

Current Home: □ House □ Apartment □ City □ Country
Is home: □ damp □ dry

Do you have house plants? □ Yes □ No How many? _____ In bedroom? □ Yes □ No

What type of heating /cooling system is in your home? _____
Is there any unusual amount of dust in your home? □ Yes □ No
Any mildew in your home? □ Yes □ No

Does your bedroom contain:
□ Feather/Down pillows/comforter □ Curtains □ Wool blankets □ Dusty mattress
Do you use a humidifier or vaporizer? □ Yes □ No

Have you made any changes in your home because of breathing problems? _____
_____

How would you describe your role in your family? _____

Which family members could help to care for you if needed? _____
_____

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Vaccinations:
Did you have a flu shot every fall? □ Yes □ No

When was your last flu shot? _____
Have you ever had the pneumonia vaccine? □ Yes □ No Date: _____

Learning Assessment:
Primary learner: □ Patient □ Mother
□ Family □ Father
□ Co-learner □ Guardian
□ Other: _____

Any barriers to learning: □ Reading □ Language □ Visual □ Hearing □ Physical
□ Emotional □ Cognitive □ Financial □ Spiritual □ Cultural
□ Other: _____

Primary language: □ English □ Spanish □ Chinese □ Japanese □ Vietnamese
□ Russian □ Arabic

nterpreter required: □ Yes □ No

Preference for learning : □ Listening □ Reading □ Demonstration □ Pictures/Video
□ Other

Review of Symptoms
General:
□ unexpected weight change □ Fever, night sweats, or chills
□ appetite change □ Fatigue

Skin:
□ rashes □ color changes □ dryness
□ itching □ changes in fingernails

Head/Ears/Nose/Throat:
□ hearing changes □ ringing in ears □ earache
□ ear drainage □ nasal congestion □ nosebleeds
□ neck stiffness □ nasal discharge □ post-nasal drip
□ neck pain □ sinus pain/fullness □ sneezing
□ sore throat □ dry mouth □ thrush
□ mouth sores □ hoarseness

Eyes:
□ vision changes □ pain □ discharge
□ redness □ last eye exam _____

New Patient History Evaluation

Cardiovascular:

□ chest pain/discomfort □ palpitations □ swelling in legs (edema)
□ calf pain with walking (claudication) □ difficulty breathing when laying down (orthopnea)
□ sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Respiratory:

□ shortness of breath □ coughing up blood □ stridor
□ choking □ wheezing □ chest tightness
□ cough - If producing sputum, what color is it? _____

Gastrointestinal:

□ swallowing difficulty □ jaundice □ heartburn/indigestion
□ rectal bleeding □ constipation □ diarrhea
□ nausea □ vomiting □ dark or bloody stools
□abdominal pain □ abdominal distention

Genitourinary:

□ change in urinary frequency □ blood in urine □ burning/pain with urination
□ incontinence □ Voiding at night □ urgency
(no. of times ___) □ hesitancy

Musculoskelatal:

□ muscle pain Where? _____ □ joint pain Where?_____
□ joint swelling Where?_____ □ back pain

Neurologic:

□ dizziness/lightheaded □ weakness Where?_____
□ fainting □ numbness Where?_____
□ headaches □ tremors Where?_____
□ seizures

Hematologic:

□ ease of bruising □ ease of bleeding □ swollen lymph nodes

Psychiatric:

□ agitation □ memory loss □ depression
□ insomnia □ waking up tired □ snoring
□ falling asleep during the day □ morning headaches