Duke Medicine
Division of Pulmonary, Allergy & Critical Care Medicine
New Patient History Evaluation

Today's Date: _____
Patient's Name: _____ Date of Birth: _____
Address: _____ Telephone: ( )_____
Referring Physician: _____ City: _____
Primary Physician: _____ City: _____

Chief Complaint/Primary Reason for evaluation:

□ COPD	□ Bronchitis	□ Cough
□ Asthma	□ Shortness of breath/dyspnea	□ Wheezing
□ Cystic Fibrosis	□ Sarcoidosis	□ Pneumonia
□ Sleep Apnea	□ Hemoptysis (coughing up blood)	□ Lung Cancer
□ Food Allergy	□ Hives	□ Allergic Reactions
□ Seasonal Allergies	□ Immune Deficiency	□ 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): _____

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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: _____
Ready to quit: □Yes □ No

Allergy History: (Please list all medications and other substances for which you are allergic of have caused an adverse reaction)

Medication/Substance	Reaction*

*Allergic/Adverse Reaction Types:

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

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Have you ever had allergy testing? □ Yes □ No
Have you ever had 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 medicines)

Medication	Dose	Route	How Often	Reason	Start Date	End Date

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

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

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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 indicate # of drinks per week)

□ Cans of beer _____ □ Shots of liquor _____
□ Glasses of wine _____ □ Drinks containing more than 5oz 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? □ Yes (inside/outside) □ No Type: _____

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

Current Home: □ House □ Apartment □ City □ Country
Is your home: □ Damp □ Dry

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

What type of heating/cooling system is in your home? _____
Is there an 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:

Do you receive a flu shot every fall? □ Yes □ No
When was your last flu shot? _____
Have you ever had a pneumonia vaccine? □ Yes □ No Date: _____

Learning Assessments:

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 □ Other: _____

Interpreter 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 drainage □ 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: _____

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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

Musculoskeletal:

□ 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