Medical CONSULTANTS
Patient Focused • Quality Oriented • Physician Driven

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New Castle	1000 North 16th, Suite 240A	New Castle, IN 47362	ph 765•521•1461	

Pulmonary History Form

Name: _____Date: _____
Referring Physician:_____Date of Birth: _____

Medical History: Please check any of the conditions that represent a SIGNICANT problem for you.

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain w/activity		Frequent urination	
Recent weight changes		Heart skips beats		Night time urination	
Fatigue		Heart beats too fast		Blood in urine	
Heat or cold intolerance		Feet or ankle swelling		Incontinence or dribbling	
Loss of appetite		Calf pain or tenderness		Change in stream	
Head and Neck	**YES**	**Lungs**	**YES**	Irregular menses (female only)	
Swelling in neck		Cough		**Gastrointestinal**	**YES**
Pain or stiffness in neck		Cough with sputum or blood		Rectal bleeding	
Skin	**YES**	Shortness of breath at rest		Blood in stool	
Change in skin color		Shortness of breath during		Chronic abdominal pain	
Rashes or dryness		walking or exercise		Heartburn or indigestion	
Bleeding, bruising tendencies		Chest pain with breathing		Constipation or diarrhea	
Eyes	**YES**	Wheezing		Black or tarry stools	
Double or failing vision		**Musculoskeletal**	**YES**	Nausea or vomiting	
Dry eyes		Swollen or red joints		Vomiting blood	
Pain or light sensitivity		Arm or leg weakness		**Endocrine**	**YES**
Ears, Nose Mouth		Difficulty walking		Night sweats	
Prolonged hoarseness		**Neurologic**	**YES**	Excessive thirst	
Sore throat		Light headed or dizziness		**Psychiatric**	
Loss of smell		Convulsions or seizures		Depression	
Nose bleeds		Numbness or tingling		Anxiety	
Runny or stuffy nose		Frequent headaches		Anorexia or bulimia	
Earache or drainage		Memory loss		Alcohol problems	
Hearing loss/ringing in ears		Snoring		Physical, verbal or sexual abuse	
Sores in mouth		Sleepiness		Drug problems	
		Sleep apnea (Stop breathing)			

If you answered yes to any of the above, please explain:

_____
_____
_____
_____
_____

Past and Family Medical History: Please check if you or your family have ever had any of the following:

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Kidney Disease			Vision Problems		
Psoriasis			Blood Disorders			Hearing Problems		
Stroke			Lupus			Low back pain		
Gout			Glaucoma			Other		

Please list all of your medications, including over the counter medications (If you need additional space please bring a list, including dosages, to your appointment.)

Name of Medication	Dosage	Number of Times Per Day	Reason for Medication

Please list all allergies including medications, food, and environmental:

Medication, Food, Other	Reaction

Please list any recent hospitalizations, and surgeries, and an approximate date of hospitalization:

Date	Reason for hospitalization or surgery

Social History:

Marital Status: Single _____ Divorced _____ Married _____ Widow/Widower _____ Other _____

Who lives at home with you? _____

Who to contact in case of an emergency and phone number:_____

Current Occupation/Employer:_____ Type of work: _____

Do you smoke? Yes _____ No _____ If yes, how many packs per day?_____

Did you smoke? Yes _____ No _____ If yes, when did you quit? _____

Do you drink alcohol? Yes _____ No _____

If yes, indicate on average how much and circle day, week, or month:

_____Beer per: Day Week Month

_____Glasses of wine per: Day Week Month

_____Mixed drinks per: Day Week Month

Patient Signature:_____ Date:_____

Physician Initials: _____ Date:_____