

North Suburban Pulmonary and Critical Care Consultants New Outpatient Visit

Please answer the following questions to help your doctor evaluate you.

Name: _____ Date: _____

<u>I. Your Past Medical History</u>	
<i>Previous Surgery (Circle, Describe, and Indicate Year)</i>	
Lung Surgery	Year
Heart Surgery	Year
Other (list)	Year
<i>Other Medical Diseases (Circle and Describe)</i>	
High Blood Pressure	
High Cholesterol	
Heart Disease	
Diabetes	
Other (List)	

<u>II. Your Social History</u>			
Do You Smoke? (Circle)	Yes	No	How Much?
Did You Ever Smoke (Circle)	Yes	No	How Much? When Did You Quit?
Are You Working Now?	Yes	No	What is Your Occupation?
Have You Ever Been Exposed to Asbestos, Dust or Strong Fumes at Work?		Yes	No Describe
Do You Keep Animals at Home?	Yes	No	Describe
Approximately How Many Drinks of Alcohol do You Consume in a Week?			

<u>III. Your Family History</u>	
<u>What Diseases Run in Your Family?</u>	<u>Relative(s)</u>
Allergies	
Asthma	

III. Your Family History (Continued)Relative(s)

Other Lung Diseases

Heart Disease

Cancer

Other (*List*)**IV. Review of Symptoms Other Than Your Breathing Problem (Circle Any You Have Experienced in the Last Three Months)**

Fever, Sweats, or Chills

Unusual Fatigue

Loss of Appetite

Weight Loss of More than 5 lbs.

Headache

Ear Aches

Eye Irritation

Blurred or Double Vision

Hoarseness

Snoring

Dry Eyes or Mouth

Nose or Sinus Problems/Hay fever

Breast Discomfort

Chest Pain

Joint Pains or Muscle Aches

Fingers that Turn White and Painful in the Cold

Numbness or Weakness of Part of Your Body

Other (*List*)

Irregular or Rapid Heart Beat

Heartburn or Indigestion

Difficulty Swallowing or Regurgitation

Nausea or Vomiting

Abdominal Pain

Diarrhea

Constipation

Bleeding

Difficult or Painful Urination

Frequent Urination

Swelling of the Ankles

Back or Neck Pain

Anxiety

Depression

Irregular Periods or Vaginal Bleeding

Automobile Accident or Serious Injury

Dizziness, Faintness, or Loss of Consciousness