San Francisco Critical Care Medical Group, Inc.

Pulmonary/ Critical Care/Sleep Disorders/Transplant Medicine
California Pacific Medical Center

Date:____________

Name:___________________________________

Date of Birth:______________________

Primary Care Physician:___________________

Reason for seeking medical attention today:

____

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Pulmonary History:

I have a history of:		**I have symptoms of:**	
Asthma	yes / no	Shortness of Breath	yes / no
Chronic Bronchitis	yes / no	Dry Cough	yes / no
COPD or Emphysema	yes / no	Coughing up phlegm	yes / no
Pneumonia	yes / no	Coughing up blood	yes / no
Tuberculosis (TB)	yes / no	Chest pains or tightness	yes / no
Lung Nodule/ Lung Mass	yes / no	Wheezing	yes / no
Hay Fever/ Allergic Rhinitis	yes / no	Fevers or Chills	yes / no
DVT/ Venous Thrombus	yes / no	Night Sweats	yes / no
Pulmonary Embolism	yes / no	Weight Loss	yes / no
Pulmonary Hypertension	yes / no	Post Nasal Drip	yes / no
Interstitial Lung Disease	yes / no	Heart Burn/ Acid Reflux	yes / no
Obstructive Sleep Apnea	yes / no	Choking on Food/ Liquid	yes / no
Sinus Disease	yes / no	Allergies/ Hay Fever	yes / no
		Stop breathing in my sleep	yes / no
		Gasping Arousals	yes / no
		Daytime Sleepiness	yes / no

I have smoked in the past yes / no Number of years__________
Packs per day____________

I have worked in a job where I was exposed to:

Dusts	yes / no	Pesticides	yes / no
Fumes/ gases	yes / no	Animal products	yes / no
Chemicals	yes / no	Plant products	yes / no
Asbestos	yes / no	Construction Materials	yes / no

If yes, please explain:____

____

Any unusual hobbies?____

____

For patients with Asthma or COPD:

I have been hospitalized on a ventilator or breathing machine yes / no When?____________________

I have wheezing episodes	yes / no	How often?__________________
I use oxygen at home	yes / no	How often?__________________
I have a nebulizer at home	yes / no	
I have taken Prednisone	yes /no	When last?__________________

Triggers for wheezing include (circle all that apply)

Tobacco smoke	Strong odors	Stress or anxiety
Cold Air	Allergies/ Hay Fever	Weather changes
Exercise	Dust	Animals
Foods	Medications	Colds/ Respiratory Infections

Exercise/ Activity Level:

I am short of breath when

Sitting Quietly	yes / no
Doing Chores at Home	yes / no
Walking Briskly	yes / no

I can walk________ flat city blocks before I have to stop
I can walk________ flights of stairs before I have to stop

Past Medical/ Surgical History (circle all that apply):

Hypertension	Kidney Failure/ Dialysis
Diabetes	Stroke
Coronary Artery Disease	Congestive Heart Failure
Heart Attack	Arrhythmia
Liver Disease	Cancer
HIV/ AIDS	Other:_____________________

Explain:____
____
____

List any hospitalizations and
surgeries:____
____
____

Social History:

Have you had a skin test for TB?	yes / no	When and what result?________________
Family history of lung disease?	yes / no	If yes, explain_______________________
I currently smoke	yes / no	Packs per day_______________________
I drink alcohol	yes / no	How much, how often?________________
I have pets at home	yes / no	If yes, explain_______________________
Any recent travel?	yes / no	If yes, where________________________
I have taken diet pills in the past	yes / no	If yes, what kind_____________________
Where were you born?_______________		When did you come to the US?_________
Current Occupation__________________		Prior Occupations_____________________

Current Medications:

____
____
____
____

Allergies to Medications:

____
____
____
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