Pulmonary and Critical Care Associates, PC

Reston: 1860 Town Center Drive, Suite 270, Reston, VA20190
Leesburg: 19455 Deerfield Ave, Suite 206, Leesburg, VA20176

PULMONARY HEALTH HISTORY FORM

Name:_____Birthdate:___/____ /___ _ Gender: **M / F**

Email address:_____Occupation:_____

Preferred Pharmacy:_____
Name **Street Address** **Phone**

Primary Language:_____Race:_____ Latino or NOT Latino?
Circle One

GENERAL MEDICAL HISTORY (Please choose as many as necessary)

☐ Alcoholism
☐ Allergies /Hayfever
☐ Anemia
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Blood Transfusion
☐ CAD
☐ Cancer Kind?_____
☐ Chemotherapy End____
☐ Radiation Treatment End_____
☐ Cardiac Pacer
☐ Cardiovascular Disease
☐ CHF
☐ Chicken Pox
☐ Cirrhosis
☐ Colitis
☐ COPD
☐ Chronic Renal Failure
☐ Crohn's Disease
☐ CVA
☐ DVT
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Epilepsy
☐ Fracture
☐ Gastric Ulcer
☐ Gastrointestinal Disease
☐ Gastroesophageal Reflux Disease
☐ Gestational Diabetes
☐ Glaucoma
☐ Heart Murmur
☐ Hepatitis
☐ High Cholesterol
☐ Hyperlipidemia
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Insulin Pump
☐ Joint Pain
☐ Kidney Disease
☐ Left Ventricular Systolic Dysfunction
☐ Kidney Infection
☐ Kidney Stone
☐ Migraines
☐ Multiple Sclerosis
☐ Myocardial Infarction
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Pneumonia
☐ Progressive Neurological Disorder
☐ Prostate Cancer
☐ Pulmonary Disease
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Shingles
☐ Sleep Apnea
☐ STD
☐ Terminal Illness
☐ Thyroid Disease
☐ TIA
☐ Tuberculosis
☐ Valvular Problems

HOSPITALIZATIONS _____
_____
_____

OTHER MEDICAL HISTORY _____

TOBACCO ASSESSMENT

Smoking Status
□ Current Every Day Smoker
□ Current Some Day Smoker
□ Former Smoker
□ Never Smoked
□ Smoker- Current Status Unknown
□ Unknown

Y N Tobacco User

# of Pack(s) smoked per day_____ Smoked for how many years?_____ Date quit smoking_____

Name: _____

SOCIAL HISTORY

Alcohol Use
- □ Non Drinker
- □ Occasional
- □ Social Drinker
- □ Moderate Consumption
- □ Heavy Consumption
- □ Recovering Alcoholic
- □ Beer Drinker
- □ Wine Drinker
- □ Never Drank Alcohol
- □ Discontinued

Caffeine Use
- □ 0 servings per day
- □ Occasional
- □ 1+ Servings per day
- □ 2+ Servings per day
- □ 3+ Servings per day
- □ 4+ Servings per day

Occupation:_____

Educational level
- □ Grades 9-12
- □ Technical/Vocational School
- □ Junior College
- □ Associates Degree
- □ Bachelor Degree
- □ Master's Degree
- □ PhD
- □ Doctorate

Marital Status
- □ Single
- □ Married
- □ Divorced
- □ Significant Other
- □ Widow
- □ Widower

Exercise Habits
- □ Sedentary
- □ Moderate <3 x/wk
- □ Moderate >3 x/wk
- □ Strenuous <3 x/wk
- □ Strenuous >3 x/wk

SURGICAL/PROCEDURAL

☐ NO PRIOR SURGICAL HISTORY

☐ Appendectomy
☐ Breast Lumpectomy
☐ Cataract Surgery
☐ Colectomy
☐ Subtotal Colectomy
☐ Cone Biopsy
☐ D & C
☐ Endometrial Ablation
☐ Gall Bladder
☐ Heart Surgery
☐ Hemorrhoids
☐ Hernia
☐ Hysterectomy
☐ Joint Replacement
☐ Laparoscopy
☐ Mastectomy Right Left Bilateral
☐ Myomectomy
☐ Oophorectomy
☐ Ostomy
☐ Splenectomy
☐ Tonsil / Adenoidectomy
☐ Tubal Ligation

OTHER SURGICAL HISTORY:

_____

_____

PREVENTIVE CARE

Flu Vaccine Date: _____
Pneumococcal Vaccine _____
Prevnar 13 _____
Zoster _____

Name:_____

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Prescriptions					
Name of medicine	**Dose** (Total mg's)	**How Many Times Per Day?**	**When do you take it?** (Am Pm and/or after meals?)	**Who Prescribed it, for you?** (Doctor's Name)	**Do you have any side effects?** (If so, describe them)
Over-the-counter medications, herbal remedies, and vitamins					

Allergies & Reactions (environmental and medications) **Very Important**	
ALLERGY	**REACTION**