Patient Information Form

*******Please fill out the following form to the best of your knowledge********

Patient Name: _____ **DOB:** _____

Reason for Visit: _____

Preferred Pharmacy/ies: _____ **Preferred Hospital:** _____

Physicians with whom we should share info.: _____

Allergies: ☐ None **Advanced Directive:** ☐ YES ☐ NO I have an Advanced Directive
☐ I would like more information

Drug	Adverse Reaction

Other (i.e. Latex, IV dye): _____

Medications: ☐ None *****Please include all breathing medications, nebulizers, and insulin doses*****

Name of Drug	Dosage	Times per Day	Reason for Taking

Vaccines: ☐ Influenza Date: _____ ☐ Pneumonia Date: _____

☐ BCG Date: _____ ☐ None

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other**_____

Ethnicity and Race:

☐ White
☐ Black / African American
☐ Asian
☐ Hispanic or Latino
☐ Other
☐ Native Hawaiian / other Pacific Islander
☐ American Indian / Alaska Native

Medical History: **DOB:** _____

- ☐ COPD
- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Pulmonary Fibrosis
- ☐ Asthma
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Cancer: Type and Location: _____

Treatment (e.g. chemo, radiation, surgery):_____

- ☐ Kidney Failure
- ☐ Sleep Apnea
- ☐ Hypertension
- ☐ Stroke
- ☐ Blood Clots
- ☐ Pulmonary Hypertension
- ☐ Hepatitis

- ☐ Autoimmune Disease
- ☐ Seizures
- ☐ GERD/Heartburn
- ☐ Allergic rhinitis
- ☐ Atrial fibrillation

Other: _____

Surgical History:

- ☐ Appendectomy
- ☐ Gall Bladder
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Knee/Hip Replacement
- ☐ Hysterectomy
- ☐ Hernia Repair
- ☐ Sinus Surgery
- ☐ Heart Bypass

Other: _____

Family History:

Relationship	Age(s), Living or at Death	Medical Conditions and/or Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		
Grandfather(s)		
Grandmother(s)		
Children		

Social History:

Marital Status: Married Single Widowed Divorced

Pets at home/work: Y or N If yes: Type/Breed: _____

Tobacco Use: Y or N If yes: Type: Cigarette Cigar Pipe Chew/Snuff

Age of start: _____ Packs/day: _____ Quit date: _____

If no: Any second-hand smoke exposure: _____

Alcohol Use: Y or N If yes: Type(s) of alcohol: _____ Drinks per week: _____

Drug Use: Y or N If yes: Type and amount: _____

Caffeine Use: Y or N If yes: Amount per day: _____

Social History (cont): **DOB: _____**

Tuberculosis: Y or N If no: Date of last PPD: _____

If yes: Date of last chest x-ray: _____ Date of treatment: _____

Occupation(s): _____

Date of Retirement: _____

Occupational/Environmental Exposures:

- ☐ Asbestos
- ☐ Hay/Farming
- ☐ Metal work/fumes
- ☐ Sandblasting/Painting
- ☐ Brick Laying
- ☐ Pigeon/Bird Exposure
- ☐ Coal
- ☐ Vicks Mentholatum
- ☐ Chemicals Type: _____
- ☐ Hot tub/Jacuzzi

Health Care/Screening:

- ☐ Colonoscopy Date: _____
- ☐ Mammogram Date: _____
- ☐ Prostate (PSA) Date: _____
- ☐ Dexa Scan Date: _____
- ☐ GYN exam/Pap Date: _____
- ☐ Sleep Study Date: _____
- ☐ Echocardiogram/Stress Test Date: _____
- ☐ Pulmonary Function Test Date: _____

Other:

Recent travel history: _____

Prior intubations: _____

Date of most recent hospitalization: _____ If so, reason: _____

Recent antibiotics (Name(s) and duration): _____

Recent steroid use (Date and duration): _____

DME

Do you have a current Oxygen supplier?: Y or N If yes: Supplier Name: _____

Review of Systems

General:

___ Fever
___ Chills
___ Weight Loss
___ Fatigue
___ Weight gain
___ Night Sweats
___ Headaches
___ Loss of appetite
___ Insomnia

___ Palpitations
___ Irregular heart beat
___ Chest pressure

Lungs:

___ Cough
___ Wheezing
___ Coughing up blood
___ Shortness of breath
___ Pleurisy
___ Sputum production

Neurologic:

___ Loss of consciousness
___ Seizures
___ Dizziness
___ Strokes
___ Tremors/shaking
___ Numbness/tingling
___ Memory loss
___ Use of walker/wheelchair/cane
___ Coordination problem
___ Headache

Head/Neck:

___ Dry mouth
___ Dry eyes
___ Enlarged thyroid
___ Ear ache
___ Hearing loss
___ Cataracts/Glaucoma
___ Vision loss
___ Post-nasal drip
___ Sinusitis
___ Nose bleeds
___ Nasal polyps
___ Tongue/mouth pain

Throat:

___ Hoarseness
___ Tongue pain
___ Swelling
___ Problems swallowing
___ Sore throat

Genitourinary:

___ Bloody urine
___ Incontinence
___ Pain with urination
___ Decreased urine stream
___ Kidney dysfunction
___ Urination at night

Cardiovascular:

___ Chest pain

Gastrointestinal:

___ Nausea
___ Vomiting
___ Abdominal pain
___ Red/maroon stool
___ Blood in vomit
___ Hemorrhoids
___ Indigestion
___ Heartburn/reflux
___ Diarrhea
___ Constipation

Musculature:

___ Weakness
___ Difficulty standing
___ Unsteady gait
___ Muscle pain
___ Shortness of breath bending over
___ Cramping
___ Bone fracture
___ Joint pain/swelling
___ Back pain

Skin:

___ Rash
___ Cyanosis (blue skin)
___ Suspicious lesions
___ Jaundice (yellow skin)
___ Easy bruising

Psychiatric:

___ Anxiety
___ Depression
___ Irritability
___ Agitation

Endocrine:

___ Change in hair growth
___ Excessive hunger / thirst
___ Goiter (lump in neck)
___ Heat / Cold intolerance
___ Night sweats
___ Day sweats

Lymphatic:

___ Lower extremity edema
___ Lymph node pain/ enlargement
___ Lymphedema

Allergy/Immunology:

___ Seasonal allergies
___ Sneezing
___ Runny nose
___ Itchy eye
___ Hives

Print Patient Name: _____ **DOB:**_____

Patient Signature: _____ **Date:** _____