PULMONARY & CRITICAL CARE CONSULTANTS OF AUSTIN, L.L.P.
NEW PATIENT FORM

HISTORY & PHYSICAL

REFERRING PHYSICIAN______________________________
First Name Last Name

PRIMARY CARE PHYSICIAN______________________________
First Name Last Name

LIST THE SPECIALISTS YOU SEE: ______________________________

____

PATIENT NAME:________________________________ **AGE:**_______ **DATE:**______________

1. What is the reason for your visit today? What are your symptoms?

____

____

____

2. How long have you had these symptoms:

____

3. Has the respiratory problem: improved worsened stayed the same

4. On a scale of 0-5 (0 is not at all, 5 is intolerable) how badly does your problem bother you? ______________

5. Does anything make the problem better or worse?

____

____

6. Have you changed your lifestyle or activities because of your respiratory problem? ☐ Yes ☐ No
If yes, explain

____

____

7. When was your last flu shot?____________________
Have you had a pneumonia vaccine? ☐ Yes ☐ No When?________________

8. **MEDICAL HISTORY:** *Please check all that conditions identified in you or your immediate family members*

Condition	Self	Family	Condition	Self	Family	Condition	Self	Family
Asthma	☐	☐	Diabetes	☐	☐	Liver disease	☐	☐
Chronic bronchitis	☐	☐	Deep venous thrombosis	☐	☐	Colon/bowel disease	☐	☐
Emphysema	☐	☐	Pulmonary embolism	☐	☐	Arthritis	☐	☐
Pneumonia	☐	☐	Anemia	☐	☐	Mental illness	☐	☐
Tuberculosis	☐	☐	Cancer ____________	☐	☐	Seizures	☐	☐
Pleurisy	☐	☐	________________	☐	☐	Thyroid problem	☐	☐
Pulmonary fibrosis	☐	☐	Kidney problems	☐	☐	Sleep apnea	☐	☐
Heart attack	☐	☐	Headache/migraines	☐	☐	Glaucoma	☐	☐
Cardiac stents	☐	☐	Dizziness	☐	☐			
Congestive heart failure	☐	☐	Reflux/heartburn	☐	☐			
High blood pressure	☐	☐	Elevated cholesterol	☐	☐			
Stroke	☐	☐	Stomach ulcers	☐	☐			

PATIENT NAME:________________________________

9. **List all other medical conditions**

____

____

____

10. **List all surgeries you have had** **Approximate date**

____

____

____

____

____

____

11. **MEDICATIONS:**

List Current Prescription Medicines and over-the-counter Medicines, including inhalers, patches, oxygen, vitamins, and herbs:

Name of Medication	Dosage	Reason for Use

PATIENT NAME:___________________________

12. **DRUG ALLERGIES & YOUR REACTION TO THEM:**

Name of Medication	Reaction to the Medication

13. **PERSONAL HISTORY:**

Have you ever used tobacco? Y□ N □
___________ packs/day: _______ # of years

Do you currently use tobacco? Y□ N □
If no, when did you quit? ________

Do you drink alcohol, beer, or wine Y□ N □ # of drinks per week __________
Recreational drug use: Y□ N □
Caffeine/Cola: Y□ N □ # drinks per day _____________
Exercise regularly Y□ N □ type ________________________
Environmental allergies (pets, mold, pollen) Y□ N □ type ________________________

MARITAL STATUS: Single Married Widowed Divorced Separated Partnered

OCCUPATION (*list past and current occupations*)

____
____
____

PETS: Do you have pets at home: Y□ N □ Dogs ________ Cats______ Birds______ Other___________

EXPOSURE HISTORY: Asbestos ________________ Tuberculosis _______________

PLACE OF BIRTH: ______________________

RECENT TRAVEL:

____

HOBBIES:

____

14. **REVIEW OF SYSTEMS:** *If you have had trouble with any of the following **in the last year**, check the problem(s).*

GENERAL: □ **None apply**
□ Decrease in appetite □ Fatigue □ Weakness □ Fever
□ Unintentional weight loss, how much____________ over how long______________
□ Weight gain, how much_____________ over how long_______________

SKIN: □ **None apply**
□ Rashes □ Easy bruising □ Hives □ Changes in skin □ Changes in hair □ Changes in nails

EYES: □ **None apply**
□ Pain □ Blurring vision □ Redness □ Dryness □ Excessive tearing

EARS: □ **None apply**
□ Drainage □ Ringing □ Earache □ Hearing Loss

NOSE: □ **None apply**
□ Nosebleeds □ Nasal discharge □ Post nasal drip □ Sinus pain □ Chronic nasal congestion

MOUTH: □ **None apply**
□ Oral lesions □ White patches □ Bleeding gums □ Toothaches

THROAT: □ **None apply**
□ Hoarseness □ Swelling □ Difficulty swallowing

LUNGS: □ **None apply**
□ Shortness of breath □ Wheezing □ Cough □time of day _______________
□ Phlegm/sputum [ ] how much ______________ □ Discolored □ Clear □ Coughing blood

HEART & CIRCULATION: □ **None apply**
□ Chest pain, radiating tightness or pressure □ Heart fluttering or racing □ Ankle/leg swelling Is this new? Yes/No
□ Difficulty breathing when lying down □ Fast heartbeat □ Slow heartbeat □ Awakening due to shortness of breath

URINARY: □ **None apply**
□ Frequent urinating □ Urinating at night □ Blood in urine □ Painful urination

STOMACH, INTESTINES AND COLON: □ **None apply**
□ Nausea □ Vomiting □ Diarrhea □ Indigestion □ Heartburn □ Constipation
□ Flatulence □ Bloating □ Belching □ Sour taste in mouth

MUSCLES, JOINTS & BONES: □ **None apply**
□ Joint stiffness or pain □ Joint swelling □ Joint redness □ Backache □ Muscle pains □ Muscle cramps
□ Limitation of joint or muscle movement □ Bone pain

NERVOUS SYSTEM: □ **None apply**
□ Fainting □ Tremors □ Paralysis □ Tingling of part of body □ Memory loss □ Headaches

HORMONES: □ **None apply**
□ Heat intolerance □ Cold intolerance □ Excessive thirst □ Excessive hunger

PSYCHOLOGICAL: □ **None apply**
□ Depression □ Difficulty sleeping □ Difficulty concentrating □ Alcohol and drug abuse
□ Nervousness □ Loss of interest in activities that are normally enjoyed
□ Snoring □ Fall asleep easily during the day □ Stop breathing when asleep

If you are presently using a medical equipment company, what is the name?

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Thank you for completing this questionnaire.

___________________________________ SIGNATURE

___________________________________ Physician

___________________________________ PRINTED NAME