Florida Cardiopulmonary Center
Central Florida Pulmonary Consultants

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Please fill out all pages as completely as possible.

NAME _____ Date of Birth _____ Age_____

DATE _____ Referring Physician _____

CHIEF COMPLAINTS:

_____

_____

_____

PAST MEDICAL HISTORY (Have you had these?)

RESPIRATORY:

Bronchial Asthma Yes _____ No _____
COPD/Emphysema Yes _____ No _____
Pneumonia Yes _____ No _____
Lung cancer Yes _____ No _____
Tuberculosis Yes _____ No _____
Pulmonary embolism Yes _____ No _____
Blood clot in legs Yes _____ No _____

ENDOCRINE

Diabetes Yes _____ No _____
High cholesterol Yes _____ No _____
Thyroid disorder Yes _____ No _____

NEUROLOGICAL

Stroke Yes _____ No _____
Epilepsy Yes _____ No _____

VASCULAR

Peripheral Vascular Disease Yes _____ No _____
Carotid Artery Disease Yes _____ No _____

CARDIAC:

Hypertension Yes _____ No _____
Heart attack Yes _____ No _____
Congestive heart failure Yes _____ No _____
Heart bypass surgery Yes _____ No _____
Echocardiogram Yes _____ No _____

GASTROINTESTINAL :

Peptic Ulcer Disease Yes _____ No _____
Hepatitis Yes _____ No _____
Gall Bladder Disease Yes _____ No _____
Bowel Disorder Yes _____ No _____

UROLOGICAL

Kidney Disease Yes _____ No _____
Prostate problem Yes _____ No _____

OTHERS:

Arthritis Yes _____ No _____
Bleeding disorders Yes _____ No _____
Cancer Yes _____ No _____

LIST ANY OTHER DISEASES:

_____

_____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

_____

_____

_____

ALLERGIES *(*To the following medications, please check)

Penicillin _____ Sulfa _____ Aspirin _____ Shellfish _____ IV Dye _____

Other medications: Please name _____

Please specify reaction to above medications: _____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

FAMILY MEDICAL HISTORY **(**Has any blood relative ever had?)

YES	NO		WHO	YES	NO		WHO
____	____	Diabetes	_____ ;	____	____	Cancer	_____
____	____	High Blood Pressure	_____ ;	____	____	Stroke	_____
____	____	Heart Disease	_____ ;	____	____	Abnormal Bleeding	_____

SOCIAL HISTORY

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Tobacco use:

Are you currently using tobacco? Yes ____ No ____# packs per day _____ for how many years?_____
How long after you wake up do you smoke your first cigarette?_____
How ready are you to quit? _____ Ready to quit? _____ Thinking about it? _____ Not ready to quit?
Did you use tobacco in the past? Yes ____ No ____ # packs per day _____
For how many years?_____ Date you quit _____

Alcohol Use

Do you use alcohol regularly? Yes_____ No_____
How much per day? _____ For how many years?_____
Did you use alcohol in the past? Yes ____ No _____
How much per day? ____ For how many years?_____ Date you quit_____

Pets at home:_____ All occupational exposures:_____
List places lived:_____ Travel in last 2 years:_____

REVIEW OF SYSTEMS

CARDIAC

Shortness of breath	Yes _____	No _____
Chest pain	Yes _____	No _____
Heart Palpitations	Yes _____	No _____
Dizziness, fainting	Yes _____	No _____
Ankle Swelling	Yes _____	No _____

ENDOCRINE

Excessive Thirst	Yes _____	No _____
Increased urination	Yes _____	No _____
Heat or cold intolerance	Yes _____	No _____
Rising to Void, more than once per night	Yes _____	No _____

NEUROLOGICAL

Severe Headaches	Yes _____	No _____
Confusion	Yes _____	No _____
Weakness in Arm/Leg	Yes _____	No _____
Transient Blindness	Yes _____	No _____

VASCULAR

Calf Pain on Ambulation	Yes _____	No _____
Numbness/Tingling in Feet	Yes _____	No _____

RESPIRATORY

Cough	Yes _____	No _____
Spitting of blood	Yes _____	No _____
Wheezing	Yes _____	No _____

GASTROINTESTINAL

Abdominal pain or heartburn	Yes _____	No _____
Nausea, vomiting	Yes _____	No _____
Diarrhea	Yes _____	No _____
Constipation	Yes _____	No _____
Blood in Stool	Yes _____	No _____

GENERAL REVIEW

Weight change	Yes _____	No_____
Extreme Fatigue	Yes _____	No _____
Fever	Yes _____	No _____
Joint pains	Yes _____	No _____
Excessive bruising	Yes _____	No _____
Impaired sight	Yes _____	No _____
Nose bleed	Yes _____	No _____
Anxiety	Yes _____	No _____