Florida Cardiopulmonary Center
Central Florida Pulmonary Consultants

KARUNA AHUJA, M.D, F.A.C.C
Diplomat ABIM, Pulmonary,Critical Care & Sleep Medicine
Assistant Professor, UCF College of Medicine

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	_____

Florida Cardiopulmonary Center
Central Florida Pulmonary Consultants

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 _____