# Lewis Gale Physicians Pulmonary Department

Please fill out and bring to your first appointment

**Date** ___________________________

**Last Name** _______________________**First** ____________________**Middle** ____________

**Reason you were sent:** _______________________________________________________

**Drug Allergies**: _____________________________________________________________

**Medical Problems**: __________________________________________________________

_____________________________________________________________________________

**Past Surgeries**: ______________________________________________________________

_____________________________________________________________________________

**Medications:** (current including birth control pills, sleeping pills and over the counter drugs)

1.____________________________________ 9. __________________________________

2.____________________________________ 10.___________________________________

3.____________________________________ 11.___________________________________

4.____________________________________ 12.___________________________________

5.____________________________________ 13.___________________________________

6.____________________________________ 14.___________________________________

7.____________________________________ 15.___________________________________

8.____________________________________ 16.___________________________________

**Immunizations:** Last Flu Shot ___________ Last Pneumonia Vaccine ____________ Last TB skin test ________

**Personal History:**

Smoking History: aged started ____ age quit ____ packs per day ___ pipe bowls per day ____ cigars per day ____

Alcohol History: type of alcohol __________amount per day ________ Number of years _______

Hobbies: ______________________________________________________________

Pets: _________________________________________________________________

Military Experience: _____________________________________________________

Occupational History: ___________________________________________________

| Family History | Age | State of Health | Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother (s) | | | |
| | | | |
| | | | |
| Sister (s) | | | |
| | | | |
| | | | |
| Children | | | |
| | | | |
| | | | |

**Circle any other problems in the Family**.

Cancer (type of cancer) _________________ Diabetes High Blood Pressure Stroke Asthma Heart Attack

Tuberculosis Emphysema Blood Clots Sleep Apnea Pulmonary Fibrosis

**Review of systems: Review the list below and circle any that describes a problem that you are having or have had**.

Fever Chills Sweats Weight Loss Change in Appetite Snoring Excessive Daytime Sleepiness

Sinus or Nasal Congestion Vision Changes Hearing Changes Shortness of Breath Wheezing

Coughing Producing Sputum (color _________) Blood in Sputum Chest Pain Palpations Racing Heart Beats

Swelling in Legs or Arms Nausea Vomiting Diarrhea Constipation Blood in Stool Black or Tarry Stools

Liver Problems Reflux/Ulcers

Arthritis Joint Swelling Muscle Aches Muscle Cramps Joint Pain Stroke Seizures Loss of Consciousness

Headaches Poor Memory Poor Balance Hot or Cold Intolerances Easy Bruising Easy Bleeding Anemia

Cancer Depression Anxiety Suicidal Thoughts

**Physician Notes :**

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**Impression**: ___________________________________________________________________________________

**Plan/Orders**: __________________________________________________________________________________