Allergy + Pulmonary ASSOCIATES

NEW PATIENT HEALTH SURVEY Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Referring/Family Doctor: _____Tel #: _____

Describe the reason(s) for your visit: _____

From the list below, CHECK your symptoms:

☐ Difficulty Breathing	☐ Shortness of Breath	☐ Wheezing
☐ Cough/Congestion	☐ Coughing Blood	☐ Chest Pain
☐ Recurrent Pneumonia	☐ Bronchitis	☐ Lung Nodule/Mass
☐ Snoring	☐ Sleep Apnea	☐ Excess Sleepiness
☐ Insomnia	☐ Restless Legs	☐ Sleep Walking

☐ Other: _____

From the list below, CHECK any prior Lung/Sleep History:

☐ Asthma	☐ COPD	☐ Emphysema
☐ Pulmonary Fibrosis	☐ Pneumonia	☐ Chronic Bronchitis
☐ Lung Cancer	☐ Lung Nodules	☐ Pleural Effusions
☐ Pulmonary Hypertension	☐ Tuberculosis	☐ Pulmonary Embolus
☐ Deep Vein Thrombosis (DVT)	☐ Asbestos Exposure	☐ Sleep Apnea
☐ Narcolepsy	☐ Restless Leg Syndrome	☐ Insomnia

Describe your current symptoms/complaints:

_____

_____

When did they start? _____

Any treatment/medications tried? _____

Any testing to date (X-rays/CT Scans)? _____

Past Medical History: Check any of the Medical Conditions below if you've ever had them:

- ☐ HIV/AIDS
- ☐ Alcohol/Drug Use
- ☐ Allergy
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Bronchiectasis
- ☐ Cancer (type): _____
- ☐ Chronic Bronchitis
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ DVT
- ☐ Diabetes
- ☐ Disc Disease
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Environmental Toxin Exposure
- ☐ Gallstones
- ☐ Gastritis/Ulcers
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack (MI)
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Kidney Failure/Dialysis
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Lupus (SLE)
- ☐ Meningitis
- ☐ Mitral Valve Dis.
- ☐ Multiple Sclerosis
- ☐ Sleep Apnea (OSA)
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Seizure/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ UTI
- ☐ Other:_____
- _____
- _____
- _____

Past Surgical History: Please check any Surgeries/Procedures you have had:

- ☐ Breast Biopsy/Surgery
- ☐ Bronchoscopy
- ☐ Cardiac Catheterization
- ☐ Dialysis
- ☐ Gallbladder Surgery
- ☐ Joint Replacement
- ☐ Pacemaker/AICD
- ☐ Prostate Surgery
- ☐ Snoring Surgery

☐ Cardiac Stent Placement ☐ Kidney Surgery ☐ Tonsillectomy

☐ Coronary Artery Bypass ☐ Lung Surgery ☐ Organ Transplant

☐ Chemotherapy ☐ Open Heart Surgery (Valves) ☐ Other: _____

List all your medications with doses (or bring an updated list to your visit):

Medication:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List your medication allergies: Check if none: ☐ None

_____	_____
_____	_____
_____	_____

Have you had recent Chest X-rays or CT Chest Scans? ☐ Yes ☐ No

Location of your X-rays/CT Scans? _____

(Please bring copies of your X-rays/CT Scans on a computer disc with you to your appointment)

Have you been Hospitalized in the last year? ☐ Yes ☐ No Location: _____

(Please bring copies of records from your hospitalization with you to your appointment)