ASHEVILLE PULMONARY AND CRITICAL CARE ASSOCIATES, P.A.

**Name:** _____ **Date:**_____

## Asheville Pulmonary & Critical Care Associates
## New Patient Information

**Reason for visit today:** _____

**Do you use Oxygen? YES or NO Supplier?** _____
**Oxygen Liter flow** _____
**How do you use O2 (circle)? exertional 24/7 nocturnal**

**Do you use CPAP? YES or NO Supplier?** _____

**Do you use BIPAP? YES or NO Supplier?** _____

**Do you use a nebulizer? ? YES or NO Supplier?** _____

**List the medications you are taking with their doses or attach a list:**

**Local Pharmacy?** _____ **Location?** _____

**Mail order Pharmacy?** _____ **Address & Phone #** _____

_____

**1:**_____

**2:**_____

**3:**_____

**4:**_____

**5:**_____

**6:**_____

**7:**_____

**8:**_____

**9:**_____

**10:**_____

**11:**_____

**12:**_____

**13:**_____

**14:**_____

**15:**_____

**16:**_____

**List any drug allergies and the reaction to each:**

_____

_____

_____

_____

**Date of last Flu Vaccine:**_____ **Date of last Pneumonia Vaccine:** _____

# Review of Systems:

**(circle any of the following symptoms you currently have)**

**GENERAL: decreased appetite, chills, decreased energy, fever, night sweats, weight gain over 10 lbs/ over how many months?_____ weight loss over 10 lbs/ over how many months?_____ snoring, stops breathing at night, falls asleep early during day**

**SKIN: bruising, hives, or rash**

**HEENT: visual disturbances, decreased hearing, nasal congestion/ drainage, hoarseness**

**NECK: neck mass, swollen glands**

**RESPIRATORY: cough (how many months? ____), decreased exercise tolerance, shortness of breath, coughing up blood (how many months?____), coughing up mucous ( what color?_____), wheezing**

**CARDIOVASCULAR: chest pain, irregular heart beat, sleeps sitting up, swelling in legs, sleeping on more pillows (how many? _____), wakes up during the night short of breath**

**GASTROINTESTINAL: abdominal pain, change in bowel habits, difficulty swallowing, heartburn, nausea, vomiting**

**URINARY: pain with urination**

**MUSCULOSKELETAL: backache (due to arthritis? yes ____ or no____) joint pain ( due to arthritis? yes ____ or no____ ), muscle weakness**

**NEUROLOGICAL: dizziness, headaches (what time of day? _____)**
**episodes of passing out, weakness**

**PSYCHIATRIC: anxiety, depression, mood changes, panic attacks**

**ENDOCRINE: thyroid problems, diabetes (controlled by pills _____ or insulin _____)**

**HEMATOLOGY: anemia, blood clots**

## Social History:

**Do you drink alcohol? YES or NO How many drinks per day? _____**

**Have you ever smoked? YES or NO What age did you start? _____**
**Are you still smoking? YES or NO When did you quit? _____**
**On average, how many packs per day? _____**

**Who lives with you at home? _____**

**What kind of pets or animals do you have? Indoor/ Outdoor_____**

**What kind of work have you done? _____**

**Have you been exposed to asbestos? YES or NO Explain:_____**
**_____**

**Have you been exposed to chemicals? YES or NO Explain:_____**
**_____**

**Have you been exposed to Tuberculosis? YES or NO Explain:_____**
**_____**

## Travel History:

**Have you traveled outside of the country? YES or NO**
**When?_____ Where?_____**

**US states you've recently traveled or lived in?_____**

## Family History:

**(list any family members with the following problems)**

**Asthma:_____**

**COPD/ Emphysema: _____**

**Blood clots in legs: _____**

**Blood clots in lungs:_____**

**Heart Disease: _____**

**Lung Cancer:** _____

**Pulmonary Fibrosis:** _____

**Tuberculosis:** _____

**Diabetes:** _____

**Thyroid Problems:** _____

**Other Cancers (what kind):** _____

# Past Medical History:

**(list all your medical problems & any dates that apply)**

**1.** _____ **dates:** _____

**2.** _____ **dates:** _____

**3.** _____ **dates:** _____

**4.** _____ **dates:** _____

**5.** _____ **dates:** _____

**6.** _____ **dates:** _____

**7.** _____ **dates:** _____

**8.** _____ **dates:** _____

**9.** _____ **dates:** _____

**10.** _____ **dates:** _____

**11.** _____ **dates:** _____

**12.** _____ **dates:** _____

# Surgical History:

**(list all of your previous surgeries with dates)**

**1.** _____ **dates:** _____

**2.** _____ **dates:** _____

**3.** _____ **dates:** _____

**4.** _____ **dates:** _____

**5.** _____ **dates:** _____

**6.** _____ **dates:** _____

**7.** _____ **dates:** _____

**8.** _____ **dates:** _____

**9.** _____ **dates:** _____