CITRUS PULMONARY CONSULTANTS AND SLEEP DISORDERS CENTER
HISTORY & PHYSICAL

Name: _____ Date of Birth: _____ Ref. Dr: _____
Why are you here to see a pulmonary (lung) doctor? _____
Name and location of your local pharmacy: _____ Mail away? _____
Are you allergic to any medications? ❑ Yes ❑ No If so, reaction: _____
Date of last Flu Vaccine: _____ Date of last Pneumonia Vaccine: _____
Do you have hay fever? ❑ Yes ❑ No Do you have a history of Lung Cancer? ❑ Yes ❑ No

PAST SURGICAL/PROCEDURE HISTORY		PAST MEDICAL HISTORY		
Please check each one that applies to you:		Do you now or have you ever had:		
❑ Eye Surgery	❑ Lung Surgery			
❑ Gallbladder Surgery	❑ Tonsils/Adenoid Removal	❑ Diabetes	❑ Heart murmur	❑ GERD
❑ Appendix Removal	❑ Hip Surgery	❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ Colon Surgery	❑ Rectal Surgery	❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Colonoscopy	❑ Upper Endoscopy	❑ Hypothyroidism	❑ Asthma	❑ Gout
❑ Thyroid Surgery	❑ Carotid Surgery	❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Fractured Nose Surgery	❑ Heart Surgery	❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Knee Surgery	❑ Prostate Surgery			
❑ Back Surgery	❑ Hysterectomy			
❑ Shoulder Surgery	❑ Other Bone Surgeries	❑ Heart Failure	❑ Epilepsy (seizures)	❑ Liver Problems
		❑ Sleep Apnea	❑ Cataracts	❑ Tuberculosis
❑ Electrocardiogram	❑ Pulmonary Function Test	❑ Angina	❑ Kidney disease	❑ Restless Leg Syndrome
❑ Bronchoscopy	❑ Chest X-Ray	❑ Heart attacks	❑ Kidney stones	❑ Arthritis
Please list any other surgical procedures:		Please list any other medical problems:		

PERSONAL HISTORY

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other
What is your current or past occupation?
Are you currently working? ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave

Have you ever smoked? ❑ Yes ❑ No Packs per day? _____ Do you still smoke? ❑ Yes ❑ No

Do you consume alcohol? ❑ Yes ❑ No Drinks per day? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health	Age(s) at death	Cause
Father				
Mother				
Brother Sister				

Have any close family members had the following?
Tuberculosis? ❑ Yes ❑ No
Lung Cancer? ❑ Yes ❑ No
Emphysema? ❑ Yes ❑ No

Have you ever worked with any of the following occupational exposures? (Please Circle)
Factory Jobs Sandblasting Mining Jobs Construction Jobs Foundry Jobs Asbestos Exposure Dust Exposure

PLEASE CONTINUE ON BACK

REVIEW OF SYSTEMS

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats
- ❑ Chills
- ❑ Trouble sleeping
- ❑ Loss of Appetite
- ❑ Tremors/Shakes

MUSCLE/JOINTS/BONES
- ❑ Numbness/Weakness
- ❑ Joint pain
- ❑ Arthritis
- ❑ Joint swelling/redness
- ❑ Gout

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Cataracts
- ❑ Redness/Dryness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Glaucoma

THROAT/SINUS
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Allergies

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness/Loss of balance
- ❑ Fainting/Loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Stroke

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Tuberculosis

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

ENDOCRINE
- ❑ Thyroid Disorders
- ❑ Diabetes
- ❑ Excessive Thirst
- ❑ Excessive Hunger

PSYCHIATRIC
- ❑ Depression
- ❑ Unusual Thoughts
- ❑ Nervousness
- ❑ Crying
- ❑ Sadness
- ❑ Suicide Attempts

OTHER PROBLEMS:

LIST NAMES OF ALL PHYSICIANS

1.	4.
2.	5.
3.	6.