# SOUTHEASTERN LUNG CARE

***ATTENTION NEW PATIENTS – PLEASE BRING A LIST OF YOUR MEDICATIONS WITH YOU TO YOUR APPOINTMENT***

**Name:** _____ **Date of birth:** _____ **Date:** _____

**Local Pharmacy Name:** _____ **Pharmacy Phone Number:** _____

**Pharmacy Address, City, Zip:** _____

**Mail order pharmacy information (if applicable):** _____

**Place of birth:** _____ **Highest grade completed:** _____ **Religion:** _____

**Marital status:** ___ Single ___ Married ___ Divorced ___ Domestic partnership ___ Widowed

**Occupation:** ___ Working (Current occupation _____) ___ Student ___ Homemaker
___ Retired (Former occupation _____) ___ Disabled ___ Unemployed

## PAST MEDICAL HISTORY (check if appropriate):

| Yourself | | Yourself | | Yourself | |
|---|---|---|---|---|---|
| □ | Alpha-1 Antitrypsin deficiency | □ | Heart attack | □ | Pneumonia |
| □ | Arthritis | □ | Hepatitis | □ | Renal disorders |
| □ | Asthma | □ | Hiatal Hernia | □ | Restless Legs Syndrome |
| □ | Blood clots | □ | High blood pressure | □ | Rheumatic fever |
| □ | Blood transfusion | □ | HIV infection | □ | Sarcoidosis |
| □ | CAD | □ | Insomnia | □ | Scleroderma |
| □ | Cancer | □ | Lung disease | □ | Seizure disorder |
| □ | CHF | □ | Lung mass | □ | Sleep apnea |
| □ | Chronic bronchitis | □ | Lupus | □ | Snoring |
| □ | COPD | □ | Narcolepsy | □ | Stroke |
| □ | Diabetes | □ | Osteoporosis | □ | Thyroid disease |
| □ | Emphysema | □ | Other heart disease | □ | Tuberculosis |
| | | | | □ | Ulcers |

## FAMILY MEDICAL HISTORY (check if appropriate):

Family Member (specify)

- ☐ Arthritis — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Asthma — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Blood clots — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ CAD — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Diabetes — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Emphysema — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Heart attack — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ High blood pressure — □ Father □ Mother □ Brother □ Sister □ Other

Family Member (specify)

- ☐ Lung disease — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Lupus — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Osteoporosis — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Renal disorders — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Sarcoidosis — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Sleep apnea — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Stroke — □ Father □ Mother □ Brother □ Sister □ Other
- ☐ Alpha 1 Antitrypsin Deficiency — □ Father □ Mother □ Brother □ Sister □ Other

**LIST ALLERGIES:** _____

# SOUTHEASTERN LUNG CARE

**Name:** _____ **Date of birth:** _____ **Date:** _____

**LIST ALL OPERATIONS:**

| | Date | Hospital | Procedure |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST TWO YEARS?**

| | Date | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**CURRENT HABITS:** ____ I **currently** smoke ___ packs per day for ___ years ____ I **never** smoked

____ I **formerly** smoked ___ packs per day for ___ years; I quit smoking (when?) _____

**ALCOHOL CONSUMPTION:** _____ # of drinks per (circle one) day/week/month

**PATIENTS OVER 65 –** Have you received a pneumonia vaccine? ☐ Yes ☐ No If yes, date: _____

**REVIEW OF SYSTEMS – (check symptoms you experienced):**

**CONSTITUTIONAL:**
- ☐ change in weight
- ☐ fever/chills
- ☐ night sweats

**RESPIRATORY:**
- ☐ shortness of breath
- ☐ cough
- ☐ coughing up blood
- ☐ wheezing

**CARDIAC:**
- ☐ chest pain/discomfort
- ☐ racing/irregular heartbeat
- ☐ ankle swelling
- ☐ aching legs when walking

**ALLERGIC:**
- ☐ allergies to dust, pollen
- ☐ allergies to animals
- ☐ seasonal hay fever

**SLEEP:**
- ☐ excessive sleepiness
- ☐ insomnia
- ☐ loud snoring
- ☐ leg pain at night

**EYES, EARS, NOSE, THROAT:**
- ☐ ringing in ears
- ☐ frequent bloody nose
- ☐ sinus infection
- ☐ hoarseness

**GASTROINTESTINAL:**
- ☐ nausea/vomiting
- ☐ difficulty swallowing
- ☐ heartburn
- ☐ abdominal pain

**NEUROLOGIC:**
- ☐ frequent headache
- ☐ numbness/tingling
- ☐ seizures

**HEMATOLOGIC:**
- ☐ anemia
- ☐ enlarged lymph nodes
- ☐ blood clots

**PSYCHIATRIC:**
- ☐ anxiety
- ☐ depression
- ☐ drug abuse
- ☐ alcohol abuse

☐ **NONE OF THE ABOVE SYMPTOMS APPLY TODAY**

I have reviewed the past medical history, medications, social history, family history, and review of systems during this visit.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Patient | Physician | Clinical staff member | Date |


*Updated 9/23/2025*