IRMC
PHYSICIAN GROUP
THE COMMUNITY'S CHOICE

Clinical Information: Pulmonary/ Critical Care Medicine

Date: _____

Patient Name: _____ _____ _____
Last First Middle

Physician Referred By: _____

Primary Care Physician: _____

Pharmacy Name: _____

Prescription Allowance: ☐ 1 month ☐ 2 months ☐ 3 months

Reason(s) for Being Seen Today: (Check all that Apply)

☐ Shortness of Breath ☐ Asthma ☐ Cough ☐ COPD ☐ Abnormal Test Findings

Other:_____

Current Medications: (if you have a list, please give to the receptionist instead)

Name	Dosage	Frequency	Name	Dosage	Frequency

Inhalers: (How many puffs/ how many times per day)

_____
_____
_____

Allergies and Reactions to Medications:

_____
_____
_____

Immunizations: (Please list year) Flu_____ Pnemonia_____ Shingles_____

Family History of Diseases: (Please list what they are)
Mother:_____
Father:_____
Brother:_____
Sister:_____

Past and Current Medical Problems: (Circle all that apply)

☐ Arthritis ☐ Asthma ☐ Cancer (Type):_____ ☐ COPD ☐ Diabetes (Type):_____

☐ GERD/Reflux ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Sarcoidosis

☐ Sleep Apnea ☐ Other:_____

Surgery and Dates:

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Number of Children: _____

Occupation and Years Worked (If retired, previous occupation):_____

_____

Smoking History: ☐ Never ☐ Currently Smoking ☐ Quit Smoking

Age Started: _____ **Quit at Age:** _____ **Number of Packs a Day:** _____

Do you use oxygen? ☐ Yes ☐ No **Liter Flow while:** Resting:____ Asleep:____ Walking:____

Do you use a CPAP or BIPAP Machine? ☐ Yes ☐ No **Settings:** (if known)_____

Do you have sleep apnea? ☐ Yes ☐ No

Do you own a pet? ☐ Yes ☐ No **Type:** ☐ Cat ☐ Dog ☐ Bird ☐ Other:_____