



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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies and Reactions to Medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Immunizations:** (Please list year) Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ 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:\_\_\_\_\_