DATE____________ HISTORY & PHYSICAL Name___________________

PCP___________________

PATIENT	PHYSICIAN
Why are you here to see a lung doctor?	cc:
Check off any problems that apply to you: o Short of breath on ground level o Short of breath on stairs/incline o Wheezing o Unable to lay flat o Night sweats o Coughed up blood o Coughed up sputum o Chest pain or pressure o Dizziness o Swollen legs o Snoring o Daytime sleepiness Have you ever had: o Sleep study o Pulmonary Function Test o Chest X-ray or CT o Echocardiogram o Bronchoscopy o Lung biopsy or surgery o Heart surgery o Blood clots o Tb exposure	HPI:
Are you being treated for any illnesses? List:	PMH:
Have you ever had surgery? List:	PSH:

DATE___________ **HISTORY & PHYSICAL** Name__________________
PCP__________________

PATIENT	PHYSICIAN

Check if your parents, siblings or children have:
o Heart problems
o Lung problems
o Cancer
Any other health problems in your family?
 	
Marital Status _____________________
Occupation________________________
Lung disease risk: Check if you have:
o Asthma
o Worked around chemicals
o Ever smoked, if so:
    o How many years__________
    o How many packs/day______
    o Quit? __________________
o Second hand smoke exposure
o Asbestos exposure
Recreational drug use __________________
Do you exercise? If so, describe:
	FH/SH:

List all medication allergies Have you had the following vaccinations? o Influenza, last date ____________ o Pneumococcal, last date ________	Allergies and Vaccines:
List all of your medications including over-the counter medicines: 1. _____________________ 2. _____________________ 3. _____________________ 4. _____________________ 5. _____________________ 6. _____________________ 7. _____________________ 8. _____________________ 9. _____________________ 10. _____________________	Medications:

DATE____________ HISTORY & PHYSICAL Name___________________

PCP___________________

PATIENT	PHYSICIAN
Please circle any symptom you have:	ROS: (note: Lung ROS is above)
• Lack of energy • Trouble sleeping • Loss of appetite • Weight change • Fever	Constitutional
• Vision or hearing problems • Sinus problems	HEENT
• High blood pressure • Heart attack • Palpitations • Valve problems • Congestive heart failure	Cardiovascular
• Stomach pain • Acid reflux • Diarrhea • Constipation • Black stools • Liver problem	GI
• Kidney disease • Trouble urinating • Pain with urination • Blood in urine	GU
• Joint pain • Leg swelling • Leg pain • Skin rash	Musculoskeletal/skin
• Stroke • Memory problems • Seizure • Headaches • Depression • Suicide attempt	Neuro
• Diabetes • Thyroid problems • Menopause • Hormone problems	Endocrine
• Bleeding problems • Anemia • HIV • Cancer	Hematology

DATE____________ HISTORY & PHYSICAL Name___________________

PCP___________________

PHYSICIAN NOTES

PHYSICAL EXAM

Temp_______ BP __________ HR__________ RR__________ O_2sat_______on _______

Weight_______ Height_______ BSI_______

See Dictation

Radiology

- CXR:____
- CT:____

Prior PFTs:____

Prior Lab Data:____

Impression

- ____
- ____
- ____
- ____

Plan

- ____
- ____
- ____
- ____

Follow-up____