NEBRASKA PULMONARY SPECIALTIES, LLC

Patient Name: ______________________ Age: ______ Sex: ______ Referred By: ______________

DOB: ______________ Date of Visit: ________________ Home Phone: ________________

Next of Kin: ______________________ Cell Phone: ________________

REASON FOR TODAY'S VISIT: ____

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RESPIRATORY HISTORY:

1.	Shortness of breath?	YES	No
2.	Do you have a cough?	YES	No
3.	Sputum production?	YES	No
4.	Are you coughing up blood?	YES	No
5.	Do you have any chest pain?	YES	No
6.	Do you have a sore throat?	YES	No
7.	Have you had/have a change in your voice?	YES	No
8.	Diagnosis of Asthma/COPD/Pulmonary Embolism	YES	No
9.	Do you have seasonal allergies?	YES	No

GENERAL HISTORY:

1.	Change in weight gain/loss?	YES	No
2.	Are you experiencing fever/chills?	YES	No
3.	Are you experiencing night sweats?	YES	No
4.	Are you experiencing leg swelling?	YES	No

SLEEP HISTORY:

1.	Any history of snoring?	YES	No
2.	Daytime sleepiness?	YES	No
3.	Daytime fatigue?	YES	No
4.	Morning headache?	YES	No
5.	Complaint from bed partner?	YES	No
6.	Need for sleeping aid?	YES	No
7.	Diagnosis of sleep apnea?	YES	No
8.	Use of a CPAP / BiPAP / 0_2?	YES	No
9.	Accidents / Job performance	YES	No

10. How well do you sleep at night? ____________________

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SOCIAL HISTORY:

1. Smoking history: Active / Ex-smoker YES No
2. Alcohol use? YES No
3. Do you live: alone with spouse with family facility
4. Occupation: ________________ Retired: YES No

FAMILY HISTORY:

1.	Heart disease/Stroke	YES	No
2.	Diabetes	YES	No
3.	Asthma / Allergies	YES	No
4.	Sleep disorder	YES	No
5.	Pulmonary disease	YES	No
6.	Malignancies	YES	No

Previous operations: ________________________________

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Previous hospitalizations: ____________________________

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Do you have living will? YES No

REVIEW OF SYSTEMS

1.	**Eyes, Ears, Nose**	YES	No
	a. Vision Problems/Glasses	YES	No
	b. Nasal Congestion/sinus/Polyp	YES	No
	c. Hearing problems/Aids	YES	No
2.	**Cardiac**	YES	No
	a. Chest pain/Heart Attack	YES	No
	b. History of Congestive Heart failures	YES	No
	c. History of Heart Surgery	YES	No
	c. High Blood Pressure	YES	No
	c. Palpitation/Black out spells	YES	No
	c. Blood clots/Anticoagulation therapy	YES	No
3.	**Gastrointestinal**	YES	No
	a. History of Ulcers?	YES	No
	b. History of Heartburn?	YES	No
	c. Difficulty swallowing?	YES	No
	d. Vomiting blood or blood in stool?	YES	No
	e. Constipation or Diarrhea	YES	No
4.	**Genito – Urinary Tract**	YES	No
	a. Kidney disease	YES	No
	b. Urinary infections	YES	No
	c. Incontinence	YES	No
	d. Prostate Disease	YES	No
5.	**Musculoskeletal**	YES	No
	a. Arthritis	YES	No
	b. Muscle or joint pains	YES	No
	c. Gout	YES	No
6.	**Hematology/Lymphatic**	YES	No
	a. Anemia	YES	No
	b. Bleeding disorder	YES	No
	c. Cancer	YES	No
	Where ____________ When: ____________		
7.	**Neurologic**	YES	No
	a. Chronic headaches	YES	No
	b. Stroke	YES	No
	c. Seizure disorder	YES	No
	d. Numbness/Tingling	YES	No
	e. Weakness	YES	No
8.	**Skin**	YES	No
	a. Skin rash	YES	No
	b. Eczema	YES	No
	c. Psoriasis	YES	No
9.	**Psychiatric**	YES	No
	a. Anxiety	YES	No
	b. Depressions	YES	No
	c. Any treatment Active / Past	YES	No
10.	**Endocrine**	YES	No
	a. Thyroid Problems	YES	No
	b. Diabetes	YES	No