Pulmonary & Critical Care Specialists of Dallas
3417 Gaston Ave, Suite 950 ● Dallas, TX 75246 ● Office 469-800-8070 ● Fax 469-800-8080

Patient Name: _____ **Date of Birth:** ____/____/____

Gender: Male Female **Marital Status:** Married Widowed Divorced Separated Single

Primary Care Doctor (Name, Phone #): _____

Who referred you to our clinic? _____

What is the primary reason you are seeing a lung specialist?

_____

- Do you have SHORTNESS OF BREATH? NO YES If yes, how often: _____
  (Circle all that apply) At Rest Walking Exercise
  - *HOW FAR CAN YOU WALK* before you are short of breath? _____
  - Do you *USE OXYGEN*? NO YES (If yes, how much? _____ L/min)
  - What makes your shortness of breath WORSE? **(Circle all that apply)**

  Respiratory infections ***Irritants (smoke, perfume, etc.)*** ***Emotions*** ***Pregnancy***

  Medicine (ibuprofen, etc.) ***Changes in weather*** ***Exercise*** ***Menses*** ***Thyroid Problems***

- Do you have COUGH? NO YES If yes, how *OFTEN*? _____
  - Do you cough up *MUCUS*? NO YES If yes Color _____ Amount: _____
  - Do you cough up *BLOOD*? NO YES If yes Color_____ Amount: _____

Have you recently experienced: (circle if positive)

- General: Fever Chills Weight Loss / Gain Night Sweats
- HEENT: Dry eyes/mouth Nasal Congestion Runny Nose Hoarseness
- Chest: Palpitations Chest pain with breathing Chest Tightness Wheezing
- Vascular: Swelling in legs
- Renal: Increased urination at night
- GI: Heartburn
- Skin: Skin changes Nail changes Easy bruising
- Sleep: Daytime sleepiness Snoring Wake up short of breath at night Insomnia

Additional problems: _____

MEDICATIONS:

_____
_____
_____

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ALLERGIES TO MEDICATIONS: _____

MEDICAL HISTORY: _____

_____

SURGICAL HISTORY: _____

_____

FAMILY HISTORY OF MEDICAL PROBLEMS: _____

SOCIAL HISTORY:

- **Tobacco use? None Previous Current**
  - What type (cigarette/cigar/chewing): _____
  - How long: _____ Have you tried quitting? **NO YES** How? _____
  - When quit: _____
- Alcohol use currently or in the past? **NO YES**
  - If yes, how much: ____ What type: _____ How often: _____
- Illegal drug use currently or in the past? **NO YES**
  - If yes, how much: ____ What type: _____ How often: _____

EXPOSURE HISTORY:

1. Are you exposed to ANIMALS / Do you have PETS at home? (If YES, what kind?)
   _____
2. What is your occupation? _____
3. Have you been exposed to chemicals in the air? YES NO

   If YES, what type _____
4. Have you been exposed to Asbestos? YES NO
5. Do you live in the: CITY or COUNTRY (circle one)
6. Have you travelled anywhere recently? If YES, where: _____

PREVIOUS STUDIES: (circle specific type if only one)

1. Chest X-Ray / CT Chest Date/Location: _____
2. Lung Function Tests Date/Location: _____
3. Lung Biopsy / Bronchoscopy Date/Location: _____
4. Allergy Testing Date/Location: _____
6. Sleep Study Date/Location: _____