Patient Name: _____ **DOB:** _____ ☐ **Male** ☐ **Female**

Local Pharmacy: _____
Pharmacy Name City and State

Mail Order Pharmacy: _____
Pharmacy Name City and State

Current Medications: (Include over-the-counter drugs and Natural Herbal Supplements). If you are unable to complete this medication form, please bring all medications in their original bottles to your visit.

Current Medications	Strength	Frequency
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
(11)		
(12)		
_____Oxygen _____Liters	**DME Company:_____**	
_____CPAP _____BiPAP _____APAP	**DME Company:_____**	
_____Nebulizer Machine	**DME Company:_____**	

Do you have any allergies? YES NO

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Patient's Initials: _____ Date Completed: _____ Rev Dec 2019

Past Medical History: Please ☑ all applicable medical history items

- ☐ Angina
- ☐ Asthma
- ☐ Alcoholism
- ☐ Cancer: Type_____
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes: Type_____
- ☐ Drug Dependency
- ☐ Heart Attack: Date_____
- ☐ Heartburn/Reflux
- ☐ Hepatitis: Type_____
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Migraines
- ☐ Pacemaker: Date_____
- ☐ Pneumonia /Pleurisy
- ☐ Pulmonary Embolism (Blood Clot)
- ☐ Pulmonary Fibrosis (Scarring)
- ☐ Restless Legs
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis - Have you been treated? ☐ Yes ☐No

Other: _____

<u>Major</u> Surgical History (Include Date: Month/Year)

(1) _____ (3) _____

(2) _____ (4) _____

<u>Recent (Last 5 years)</u> Hospitalizations (Month/Year) **Primary Hospital: _____**

(1) _____ (3) _____

(2) _____ (4) _____

Family History:

Father: _____Alive _____Deceased (Age), Cause of Death:_____
Mother: _____Alive _____Deceased (Age), Cause of Death:_____
Number of Brothers: _____, If deceased, indicate age and cause of death _____
Number of Sisters: _____, If deceased, indicate age and cause of death _____
Number of Sons: _____, If deceased, indicate age and cause of death _____
Number of Daughters:_____, If deceased, indicate age and cause of death _____
Paternal Grandfather: _____Alive _____Deceased (Age), Cause of Death:_____
Paternal Grandmother: _____Alive _____Deceased (Age), Cause of Death:_____
Maternal Grandfather: _____Alive _____Deceased (Age), Cause of Death:_____
Maternal Grandmother: _____Alive _____Deceased (Age), Cause of Death:_____

Do any members of your immediate family, (Mother, Father, Brother, Sister, Son, Daughter, Maternal/Paternal Grandparents) have or have had any of the following? Please respond to every option, if "Yes" note which family member(s) in Relation.

	Yes	No	Relation		Yes	No	Relation
Alcoholism				Hepatitis C			
Asthma				HIV/AIDS			
COPD				High Cholesterol			
Diabetes Type I				High Blood Pressure			
Diabetes Type II				Lung Cancer			
Heart Disease				Thyroid Disease			
Hepatitis B				Other			

Preventative Medicine

1. Have you ever received a pneumonia vaccine? ☐ Yes ☐ No
   Date of vaccine: _____
2. Have you had a flu shot since the most recent September 1st? ☐ Yes ☐ No
3. Do you currently have an advanced directive (DNR/DNI) order? ☐ Yes ☐ No
4. Do you currently have a Health Care Proxy? ☐ Yes ☐ No
   If Yes, please indicate the person responsible to carry though your advanced directive and **provide a copy of your proxy.** _____

Smoking History

1. Are you a: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

If you answered <u>Never Smoked</u> – Go to <u>Question 10</u>.

2. If 'Current Smoker': How often do you smoke? ☐ every day ☐ some days, but not every day
3. Age you began to use tobacco products? _____
4. Tobacco products used: (check all that apply)
   ☐ Cigarettes ☐ **Vaping** ☐ Cigars ☐ Pipes
5. How many <u>cigarettes a day</u> do you or did you smoke?
   ☐5 or less ☐6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more
6. How many <u>cigars per week</u> do you or did you smoke: _____/ week
7. How many <u>pipes/per week</u> do you or did you smoke: _____/ week
8. If 'Current Smoker': Are you interested in quitting?
   ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit
9. If 'Former Smoker': How long has it been since you last smoked? What <u>year</u> did you quit? _____
   ☐ < 1 month ☐ 1-3 month ☐ 3-6 months ☐ 6-12 months
   ☐ 1-5 years ☐ 5-10 years ☐ > 10 years
10. Have you ever been exposed to second hand smoke? ☐ Yes ☐ No
11. Are you Vaping? ☐Yes ☐No If Yes How often? How long have you been Vaping?

Animal/Pet Exposure

Are you exposed to animals? ☐ Yes ☐ No

☐ Feline ☐ Equine/Bovine/Farm ☐ Avian ☐ Rodent
☐ Canine ☐ Reptile ☐ Other: _____

Exercise

Do you exercise? ☐ Yes ☐ No

☐ Gym/Weightlifting ☐ Golf ☐ Aerobics/Curves ☐ Hiking
☐ Walking ☐ Swimming ☐ Running ☐ Physical Therapy
☐ Tai Chi/Yoga ☐ Pulmonary Rehab ☐ Cardiac Rehab ☐ Other: _____

Alcohol Consumption

1. Do you consume alcohol? ☐ Yes ☐ No
2. What do you drink?
   ☐ Beer ☐ Wine ☐ Liquor
3. How much do you drink?
   ☐ 1 - 2 ☐ 3 - 4 ☐ 5 or more
4. How often do you drink?
   ☐ Every day ☐ Once a week ☐ Only on weekends
   ☐ Socially ☐ Occasionally

Recreational Drug Use

1. Do you or have you ever used drugs? ☐ Yes ☐ No
   Please Choose One: ☐ Current Use ☐ Past Use
2. What types of drugs do you use or have used in the past?
   ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Methadone
   ☐ Morphine ☐ Opiates ☐ Crack Cocaine ☐ Crystal Meth
   ☐ Pain Meds ☐ Speed ☐ IV Drug Use ☐ Other: _____
3. Do you currently or have you ever injected drugs? ☐ Yes ☐ No

Caffeine Consumption

1. Do you consume any caffeine? ☐ Yes ☐ No ☐ Occasionally
2. What kind of caffeine do you drink?
   ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate/Hot Chocolate
   ☐ Espresso ☐ Iced Coffee ☐ Iced Tea ☐ Energy Drinks/Supplements
3. How much caffeine do you consume? (cups/cans)
   ☐ 1 – 2 per day ☐ 3 – 4 per day ☐ 5 per day
   ☐ More than 5 per day
4. What size cup(s) do you consume?
   ☐ Small (10 oz) ☐ Medium (14 oz) ☐ Large (20 oz)
   ☐ XL (24 oz)

Occupational Exposure

1. Current Occupation:_____ Previous Occupation: _____
2. Please indicate any current occupational exposures:_____

Have you ever traveled outside the United States? ☐ Yes ☐ No

☐ Have not traveled within the past year

Where have you traveled to? Please indicate the year traveled next to any selection, Year:_____

☐ Africa _____ ☐ India _____
☐ Aruba _____ ☐ Ireland _____
☐ Bahamas _____ ☐ Mexico _____
☐ Caribbean _____ ☐ Puerto Rico _____
☐ Canada _____ ☐ Guatemala _____
☐ Dominican Republic _____ ☐ China _____
☐ England _____ ☐ Vietnam _____
☐ Europe _____ ☐ Other:_____

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Review of Systems: *Current Personal Medical Symptoms*

Constitutional symptoms			
	Recent weight loss	Yes	No
	Recent weight gain	Yes	No
	Fever	Yes	No
	Chills	Yes	No
	Trouble sleeping	Yes	No
Eyes	Redness or itching	Yes	No
	Visual blurring	Yes	No
	Eye disease or injury	Yes	No
Ear/Nose/Mouth/Throat			
	Hearing loss	Yes	No
	Ringing in ears	Yes	No
	Earaches, infections	Yes	No
	Ear drainage	Yes	No
	Nose bleeds	Yes	No
	Frequent nasal stuffiness	Yes	No
	Runny Nose	Yes	No
	Postnasal drip	Yes	No
	Frequent sinus infections	Yes	No
	Mouth sores	Yes	No
	Swollen glands in neck	Yes	No
	Hoarse voice or voice changes	Yes	No
Cardiovascular			
	Chest pain or discomfort	Yes	No
	Tightness	Yes	No
	Palpitations	Yes	No
	Short of breath when walking	Yes	No
	Short of breath when lying flat	Yes	No
	Swelling of feet, ankles or hands	Yes	No
	Swelling of legs	Yes	No
	Sudden awakening from sleep with shortness of breath	Yes	No
Respiratory			
	Chronic or frequent cough	Yes	No
	Coughing up mucous/phlegm	Yes	No
	Coughing up blood	Yes	No
	Shortness of breath	Yes	No
	Wheezing	Yes	No
	Painful Breathing	Yes	No
	Snoring	Yes	No
Gastrointestinal			
	Abdominal pain	Yes	No
	Nausea and/or vomiting	Yes	No
	Frequent heartburn	Yes	No
	Swallowing difficulties	Yes	No
	Diarrhea	Yes	No
	Constipation	Yes	No

Urinary			
	Burning or pain (dysuria)	Yes	No
	Blood in urine (hematuria)	Yes	No
Musculoskeletal			
	Joint pain	Yes	No
	Muscle pain	Yes	No
	Swelling of joints	Yes	No
	Leg pain/cramps	Yes	No
Integumentary (skin)			
	Rash, hives or itching	Yes	No
	Lumps	Yes	No
	Change in skin color	Yes	No
	Recurrent skin infections	Yes	No
Neurological			
	Frequent/recurring headaches	Yes	No
	Dizziness	Yes	No
	Weakness	Yes	No
	Numbness or tingling sensations	Yes	No
	Restless Legs	Yes	No
	Excessive Daytime Sleepiness	Yes	No
Psychiatric			
	Nervousness	Yes	No
	Stress	Yes	No
	Depression	Yes	No
	Memory Loss	Yes	No
Endocrine			
	Cold intolerance	Yes	No
	Heat intolerance	Yes	No
	Excessive thirst or urination	Yes	No
Hematologic/Lymphatic			
	Ease of bruising	Yes	No
	Ease of bleeding	Yes	No
	Swollen glands	Yes	No
	Fatigue	Yes	No
Allergic/Immunologic			
	Hay fever symptoms (itchy, runny nose/sneezing)	Yes	No
	Known food allergies	Yes	No
	Known environmental allergies	Yes	No
	Known drug/medication allergies	Yes	No

***Additional information not listed above**:

_____

_____

Patient's Initials: _____ Date Completed: _____ Rev Dec 2019