North Mississippi Medical Center- Pulmonary Consultants

Name: _____

Reason for visit: _____

Drug Allergies: 1. _____ 3. _____

2._____ 4. _____

Medical History: Circle all that apply

Allergic rhinitis	Emphysema	Rheumatoid arthritis
Alpha 1-antitrypsin deficiency	GERD	Sarcoidosis
Anemia	HIV/AIDS	Sinus disease
Asthma	Hypertension	Obstructive sleep apnea
Bronchiectasis	Idiopathic pulmonary fibrosis	Thyroid disease
Chronic Bronchitis	Interstitial lung disease	Tuberculosis
Chronic respiratory failure	Lung Cancer	Other: _____
COPD	Lung nodule	_____
Coronary artery disease	Pleural effusion	_____
Cystic fibrosis	Pneumonia	_____
Deep vein thrombosis	Pulmonary arterial hypertension	_____
Diabetes mellitus	Pulmonary embolism	_____

Surgical History: Circle all that apply

Bronchoscopy	Lung biopsy	Pacemaker insertion	Other: _____
CABG	Lung lobectomy	Pneumonectomy	_____
Cardiac catherization	Lung transplant	Valve replacement	_____

Family History:

				Maternal		Paternal		
	Mother	**Father**	**Sibling**	**GM**	**GF**	**GM**	**GF**	**Children**
Asthma								
Cancer								
Diabetes								
Emphysema								
Heart failure								
Hypertension								
Thyroid disease								

Occupational History: 1. Job title: _____

2. Work exposures: _____

Vaccination/ Date last received:

Flu shot: _____

Pneumovax 23: _____ _____ Prevnar 13: _____ Prevnar 20: _____

COVID 19: _____ _____ _____ _____

Social History:

1. Marital Status: ___Single ___Married ___Divorced ___Widowed
2. Smoking History:

    ____Never Smoke

    ____ Currently Smoke: ____ppd Year started smoking? _____

    ____Cigarettes

    ____Cigar

    ____Pipe

    ___Vape/ e-cigarettes

    ____ Previous smoked: ____ppd ____Number of years

    _____Cigarettes

    _____Pipe

    _____Cigar

    ____ Smokeless tobacco use: ____ Dip _____Chew ____ Number of years

    ____ Passive/ Second-hand exposure
3. Marijuana: _____ Illicit drugs: _____
4. Alcohol: _____

Sleep History:

1. Do you snore? _____
2. Do you stop breathing when you are sleeping? _____
3. Usual bedtime? _____ Time wake up? _____
4. Estimated hours of sleep nightly? _____
5. How long does it take to fall asleep? _____
6. Do you have a crawling sensation in your legs when you try to sleep that goes away when you move? _____
7. Do you have headaches upon awakening? _____
8. Do you have a dry mouth in the morning? _____
9. Do you take naps? _____
10. Do you take sleeping pills? _____
11. How many caffeinated drinks do you drink daily? _____
12. How many times do you wake up at night? _____ Why? _____
13. Do you have muscle weakness with emotions, such as laughter? _____
14. Do you have any violent/ strange behaviors during sleep? _____