Olathe HEALTH
Consultants in
Pulmonary Medicine

We prefer that This paperwork be filled out prior to coming in for your scheduled appointment. If paperwork is not filled out, your appointment may be delayed. Please plan to arrive 15 minutes prior to your appointment time to give the front desk time to check you in.

PATIENT PERSONAL HISTORY

Name ____________________ Date ____________________

List your doctors, starting with your primary doctors (so we can keep them informed):

Doctor	Specialty	Hospital	Date Seen

Chief Complaint: What is the **main concern** you are here today to discuss?

____

When did you **first** notice this problem? ____________________

Describe the symptoms, if any, **when** they occur, and **how severe** they are on a scale of 0-10, 0=none and 10=very, very severe ____________________

____

____

____

OPERATIONS	
List Past Operations	**Approx. Year**

HOSPITALIZATIONS	
Past Hospitalizations (Other than Operations)	**Approx. Year**

IMMUNIZATIONS			
Name	**Date**	**Name**	**Date**
Influenza		Pneumovac	

Name ______________________________ Date ______________________

Do you use oxygen? **Yes** **No** How much and when? **Resting:** ______ **Sleeping:** ______ **Exertion:** ______

Do you use a CPAP or BIPAP? **Yes** **No** What are the settings? ______________________

Date of your last sleep study: ______________________ Where was it done: ______________________

Do you have an Advanced Directive (Living Will) or a code status? **Yes** **No**

What does it state? ____

____

Do you have a P.O.A. for medical decisions? **Yes** **No**

SOCIAL AND ENVIRONMENTAL HISTORY

Occupation or former occupation: ____
Any toxic or hazardous exposures? ____
Marital Status: **Married** ______ **Single** ______ **Widowed** ______ **Divorced** ______

Check the box of the appropriate answer. **Y** = Yes **N** = No **OC** = Occasionally

	Y	N	OC		Y	N	OC
Regular exercise				Drink coffee, tea, cola			
Smoke or use tobacco now				How much coffee, tea, cola:			
Use tobacco in the past				Drink Alcohol			
Date Tobacco Started:				What Kind Alcohol:			
Date Tobacco Stopped:				How Much Alcohol:			
List all Pets:							

TRAVEL

Have you traveled out of the country in the past 12 months? ❑ **YES**; list places below ❑ **NO**

____

____

Name ______________________________ Date ____________________

FAMILY	Living		Deceased	
Name	Age	Health	Age at Death	Cause
Father				
Mother				
Sibling / Male Female				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Husband / Wife				
Son / Daughter				
Son / Daughter				
Son / Daughter				
Son / Daughter				
Son / Daughter				

FAMILY HISTORY - Check if any **blood relative** has had any of the following and enter relationship.

	Yes	No	Relation		Yes	No	Relation
Asthma				Bleeding Tendency			
Hay fever				Heart Attack			
Emphysema				Stomach Ulcers			
Stroke				Kidney Disease			
Cancer				Goiter			
High Blood Pressure				Arthritis			
Tuberculosis				Colitis			
Diabetes				Nervous Breakdown			
Leukemia				Gout			
Epilepsy				Rheumatic Heart			
Suicide				Congenital Heart			
Migraine							

PERSONAL HISTORY - Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Anemia			Gout			Jaundice		
Hay fever			Diabetes			Hepatitis		
Freq Lung Infections			Cancer			Colitis		
Rheumatic Fever			Freq. Kidney Infections			Arthritis		
Angina Pectoris			Freq. Bladder Infections			Migraine Headache		
Heart Attack			Nervous Breakdown			Others:		
Other Heart Disease			Thyroid Disease					
High Blood Pressure			Stomach Ulcers					
Kidney Disease			Gallbladder Disease					

Name ______________________________ Date ______________________

REVIEW OF SYSTEMS - Check the box of the appropriate answer regarding your ***CURRENT*** symptoms. Use approx. dates where required. **Y** = Yes **N** = No **OC** = Occasionally

CONSTITUTIONAL	**Y**	**N**	**OC**
Tiredness			
Felt Depressed			
Gained Weight			
Lost Weight			
Trouble sleeping			
Lots of stress			
Fever			
EYES	**Y**	**N**	**OC**
Had glaucoma			
Eye pain			
Vision trouble			
Spots in vision			
Wear glasses			
CARDIOVASCULAR	**Y**	**N**	**OC**
Chest pain or tightness			
Abnormal heart rhythm			
Heart murmur			
Leg cramps w/ walking			
Abnormal - EKG			
Date of Last EKG:			
Blue or very white fingers			
Awaken to catch breath			
Sleep sitting up to breathe			
GASTROINTESTINAL	**Y**	**N**	**OC**
Heartburn			
Nausea			
Vomiting			
Vomiting Blood			
Constipation			
Hemorrhoids			
Abdominal Pain			
Diarrhea			
Use laxatives			
Blood in stools			
Black stools			
Hepatitis or jaundice in the past			
Date of last proctoscopy:			

EARS, NOSE AND THROAT	**Y**	**N**	**OC**
Had a change in hearing			
Wearing hearing aids			
Ears ringing			
Sinus trouble			
Hoarseness			
Lump in your throat			
Painful swallowing			
RESPIRATORY	**Y**	**N**	**OC**
Breathless at rest			
Breathless with exertion			
Cough			
Cough with sputum or phlegm			
Wheezing			
Excessive Snoring			
Gasping Spells			
Chest pain with deep breathing			
Exposure to Tuberculosis (TB)			
Date of last TB skin test:			
Date of last Chest X-Ray:			
GENITOURINARY	**Y**	**N**	**OC**
Pain with Urination			
Urinate very Frequently			
Get up at night to urinate			
Have trouble holding urine			
MEN	**Y**	**N**	**OC**
Impotence			
Prostate trouble			
WOMEN	**Y**	**N**	**OC**
Breast Lump			
Hot Flashes			
Change in periods			
Nipple discharge			
Date of last Mammogram:			
Date of last Pap Smear:			
Date of last Period:			

Name ________________________________ Date ________________________

SKIN - INTEGUMENTARY	Y	N	OC
Changing blemishes			
Skin lesions			
Warts			
Rash			
NEUROLOGIC	**Y**	**N**	**OC**
Headaches			
Dizzy spells			
Light headedness			
Bad memory			
Fainting			
Seizures			
Numbness			
Unsteady walking			
Slurred speech			
PSYCHIATRIC	**Y**	**N**	**OC**
Depression			
Anxious			
Change in personality			
Crying spells			
Early morning awakening			
Hearing imaginary voices			

MUSCULOSKELETAL	Y	N	OC
Joint pains			
Known tendonitis or bursitis			
Feet swelling			
Walk with limp			
Back pain			
Foot trouble			
HEMATOLOGIC – LYMPHATIC	**Y**	**N**	**OC**
Anemia			
Blood transfusion			
Date of blood transfusion:			
Easy bruising			
Free bleeding			
Swollen lymph glands			
ALLERGIC – IMMUNOLOGIC	**Y**	**N**	**OC**
Food allergy			
Seasonal runny nose			
Hives			
Frequent pneumonias			
Removal of spleen			
Had pneumonia vaccine			
Use of prednisone or steriods			
ENDOCRINOLOGIC	**Y**	**N**	**OC**
History of Diabetes			
History of Thyroid problems			
Excessive Thirst			
Night time Urination			

Do ***NOT*** complete if you completed the sleep disorders questionnaire. (green paperwork)

SLEEP	Y	N	OC
Do you wake up feeling rested?			
Do you have daytime headaches?			
Have you ever been diagnosed with sleep apnea?			
Do you snore?			
Has anyone ever seen you stop breathing while asleep?			