

NORTHERN VIRGINIA PULMONARY AND CRITICAL CARE ASSOCIATES, P.C.

BOARD CERTIFIED, PULMONARY DISEASE
BOARD CERTIFIED, CRITICAL CARE MEDICINE
*BOARD CERTIFIED, SLEEP MEDICINE

Robert Bloom, M.D.
Thomas A. McCabe, M.D.*
James P. Lamberti, M.D.
Ellen C. Vaughey, M.D.

Eric A. Libré, M.D.
Matthew D. Williams, M.D.
Adlah Sukkar, M.D.
Mark Granada, M.D.

Date: _____

Patient Name: _____

Acct #: _____

Patient DOB: _____

Family History

Check what disease run in your family and specific relative?

- | | | | |
|--|-------|---|-------|
| <input type="checkbox"/> Emphysema | _____ | <input type="checkbox"/> Hemophilia | _____ |
| <input type="checkbox"/> Multiple Sclerosis | _____ | <input type="checkbox"/> Leukemia | _____ |
| <input type="checkbox"/> Wegene'rs Granuloma | _____ | <input type="checkbox"/> Lung Cancer | _____ |
| <input type="checkbox"/> Anemia | _____ | <input type="checkbox"/> Lupus | _____ |
| <input type="checkbox"/> Arthritis | _____ | <input type="checkbox"/> Malignant Neoplasm | _____ |
| <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> Ovarian Cancer | _____ |
| <input type="checkbox"/> Breast Cancer | _____ | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| <input type="checkbox"/> Bronchiectasis | _____ | <input type="checkbox"/> Sarcoidosis | _____ |
| <input type="checkbox"/> Bronchitis | _____ | <input type="checkbox"/> Scleroderma | _____ |
| <input type="checkbox"/> Clotting disorder | _____ | <input type="checkbox"/> Sickle Cell Anemia | _____ |
| <input type="checkbox"/> Colon Cancer | _____ | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cystic Fibrosis | _____ | <input type="checkbox"/> Thromboembolic | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Tracheal Cancer | _____ |
| <input type="checkbox"/> Heart Disease | _____ | <input type="checkbox"/> Tuberculosis | _____ |

Write Details Below:

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Social History

Abestos Exposure yes no
 Do you keep animals at home? yes no
 Dust Exposure yes no

Employment Status: _____

Occupation: _____

Strong Chemicals Exposure yes no

Traveled in last year? _____ (list places and dates)

Tobacco use? yes no Never

Current smoker Average packs/day _____ Number of years smoking _____

Quit When? _____ Average packs/day _____ Number of years _____

Approximately how many drinks of alcohol do you have per week? _____

Birthplace: _____

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Review of Symptoms

Other than your breathing problem, please check and describe problems you have experienced in the past three (3) months

CONSTITUTIONAL

- Fever
- Loss of appetite
- Chills
- weight loss of more than 5 pounds
- weight gain of more than 5 pounds
- How much? _____
(unexplained weigh loss/gain)
- Night Sweats
- Malaise (Unusual fatigue)

EYES

- Double vision
- Dry eyes
- Eye discomfort (irritation)
- Changes in vision
- Blurred vision

HENT

- Headaches
- Hearing difficulty (loss)
- Dry mouth
- Hoarseness
- Vertigo (unusual dizziness)
- Sinus pain
- Nasal Discharge
- Tinnitus (ringing ears)
- Lightheadness/fainting
- Nasal Congestion
- Postnasal Drip
- Ear pain

BREASTS

- Lumps
- Breast discomfort

CARDIOVASCULAR

- Chest Pain
- Irregular heart beats
- Dyspnea on exertion
- Lower extremity edema
(swelling at ankles)
- Rapid heart rate
- Heart murmur

RESPIRATORY

- Shortness of breath
- Cough
- Wheezing
- Chest Wall Pain

GASTROINTESTINAL

- Abdominal pain
- Reflux (gastro esophageal)
- Nausea
- Constipation
- Heartburn
- Diarrhea

GENITOURINARY

- Urgency (Frequent urination)
- Hematuria (blood in urine)
- Irregular Menses
(irregular menstrual periods
or vaginal bleeding)
- Dysuria (painful urination)

INTEGUMENT

- Rash
- Skin dryness
- Itching

NEUROLOGIC

- Tingling or numbness
- Altered mental status/
loss of consciousness
- Seizures
- Sleepiness in the daytime

MUSCULOSKELETAL

- Muscle pain
- Joint pain
- Neck pain
- Back pain
- Fingers turn white &
painful of cold
- Morning stiffness

ENDOCRINE

- Polyuria
(Excessive urination)
- Polydipsia
(Excessive thirst)

PSYCHIATRIC

- Anxiety
- Depression
-

HEME-LYMPH

- Easy bleeding
- Easy bruising
- lymph node enlargement

Other Symptoms: _____

No Other Symptoms

Additional Comments:

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Pulmonary History

Check all that currently apply

- | | |
|--|---|
| <input type="checkbox"/> Intermittent cough (not related to a common cold) | <input type="checkbox"/> Daytime sleepiness |
| <input type="checkbox"/> Frequent cough in the morning | <input type="checkbox"/> Postive TB skin test in the past |
| <input type="checkbox"/> Sputum production: _____ tablespoons per day | <input type="checkbox"/> Exposure to TB |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pneumonia Date: _____ |
| <input type="checkbox"/> Chest congestion/tightness | |

Shortness of breath

Wheezing:

- | | |
|---|--|
| <input type="checkbox"/> Following a common cold | <input type="checkbox"/> During strenuous exercise |
| <input type="checkbox"/> With exercise | <input type="checkbox"/> During moderate exercise |
| <input type="checkbox"/> Seasonally (spring/fall) | <input type="checkbox"/> During normal activity |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> While at rest |
| | <input type="checkbox"/> Awaken at night |

How many blocks on level can you walk? _____

How many flights of stairs can you climb? _____

Date of last Chest X-Ray _____

Pneumococcal pneumonia vaccine-date _____

Influenza vaccine-date _____

Write Details Below:
