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PULMONARY ASSOCIATES of the Southeast, PC

LUNG DISEASES · SLEEP · ASTHMA · CRITICAL CARE

Russell G. Beaty M.D. • Kimberly D. Bridges M.D. • David P. Franco M.D. • Sandra K. Gilley M.D.
Allan R. Goldstein M.D. • Erin M. Ozgun M.D. • Alan Q. Thomas M.D.

PATIENT INTAKE FORM

(Please be sure to fill out all 3 pages of this form.)

Name: _____ Date of birth: _____

Name of Physician that referred you: _____

Briefly describe your symptoms: _____

Past Medical History:

☐ COPD ☐ Acid Reflux ☐ Hypertension ☐ Thyroid Disorder
☐ Nodule/Mass ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol
☐ Asthma ☐ Other: _____

Past Surgery History:

☐ Appendectomy ☐ Hysterectomy ☐ Gallbladder ☐ Hernia
☐ Heart Bypass ☐ Tonsils ☐ Hip ☐ Back
☐ Prostate ☐ Other: _____

Vaccines: ☐ Pneumonia (Year: _____) ☐ Influenza (Year: _____)

List the names of all medicines you take including any supplements and over the counter:

Medicine Name	Dosage	Frequency	Medicine Name	Dosage	Frequency

Allergies: ☐ None ☐ Other: _____

Family History: *Please check if your Mother, Father, Brother, Sister ever had any of the following*

☐ Lung Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes
☐ Prostate Cancer ☐ Other: _____

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Social History:

Tobacco ☐ Current / Everyday ☐ Former Years _____
☐ Current / Some Days ☐ Never Packs _____

Alcohol ☐ Current / Everyday ☐ Former Amount _____
☐ Current / Some Days ☐ Never

Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Review of Systems:

1. Are you having fatigue? ☐ Yes ☐ No
2. Have you had recent weight ☐ gain ☐ loss? If so, how much? _____
3. Are you having headaches? If so, describe: ☐ Yes ☐ No

_____

4. Are you having an earache? ☐ Yes ☐ No
5. Do you have hearing loss? ☐ Yes ☐ No
6. Visual problems not connected with glasses? ☐ Yes ☐ No
7. Sinus congestion or postnasal drip? ☐ Yes ☐ No
8. Have you been told you: ☐ Snore ☐ Stop breathing ... during sleep? ☐ Yes ☐ No
9. Have trouble getting to sleep? ☐ Yes ☐ No
10. Feel rested in the morning? ☐ Yes ☐ No
11. Excessive daytime sleepiness? ☐ Yes ☐ No
12. Shortness of breath? If so, (check) ☐ at rest ☐ with activity ☐ both ☐ Yes ☐ No
13. Do you wheeze? ☐ Yes ☐ No
14. Do you cough? ☐ Yes ☐ No

    If so, are you coughing up anything? ☐ Yes ☐ No

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Review of Systems (cont'd):

15. Do you have palpitations? ☐ Yes ☐ No

16. Do you have chest pain? ☐ Yes ☐ No

17. If so, how long does each episode last? _____ with (check) ☐ Rest ☐ Activity ☐ Both

18. Is the chest pain associated with (check): ☐ Nausea ☐ Sweating ☐ Shortness of breath

19. Does the chest pain radiate: ☐ across chest ☐ down arm ☐ up neck ☐ Yes ☐ No

20. Do you have diarrhea? ☐ Yes ☐ No

21. Do you have constipation? ☐ Yes ☐ No

22. Do you have blood in stool or dark black stool? ☐ Yes ☐ No

23. Do you have abdominal pain? ☐ Yes ☐ No

24. Do you have reflux of stomach / indigestion? ☐ Yes ☐ No

25. Do you have blood in your urine? ☐ Yes ☐ No

26. Pain or burning with urination? ☐ Yes ☐ No

27. Do you have loss of bladder control? ☐ Yes ☐ No

28. Any muscle or joint aches? ☐ Yes ☐ No

29. Any numbness or weakness in arm or leg? ☐ Yes ☐ No

30. Any anxiety or depression? ☐ Yes ☐ No

Anything else you would like for us to know about your health:

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