The Heart & Lung INSTITUTE OF UTAH

Name:_____Date: _____

Who asked that you be seen by a pulmonologist [ ] Regular Doctor [ ] Cardiologist [ ] Myself
Other:_____

Name of your Doctor/Doctors you would like our report sent to _____

Describe in your own words why you have come to see a lung doctor:_____

_____

_____

During the past year have you:

Had fevers or chills or sweating? (circle)	[ ] No	[ ] Yes	Had a change in your bowel habits?	[ ] No	[ ] Yes
Had a change in your appetite?	[ ] No	[ ] Yes	Had black or bloody bowel movements?		
Felt unusually tired all the time?	[ ] No	[ ] Yes	Had abdominal pain?	[ ] No	[ ] Yes
Had significant weight loss or gain? *(circle one)*	[ ] No	[ ] Yes	Had nausea/vomiting?	[ ] No	[ ] Yes
Had trouble sleeping?	[ ] No	[ ] Yes	Had heartburn?	[ ] No	[ ] Yes
			[ ] Day and/or [ ] night		
Had eye or vision trouble?	[ ] No	[ ] Yes	Had troubles with urination?	[ ] No	[ ] Yes
			Had troubles with your bladder?	[ ] No	[ ] Yes
Had sinus problems?	[ ] No	[ ] Yes			
Had any new hoarseness in your voice?	[ ] No	[ ] Yes	Had problems with your joints	[ ] No	[ ] Yes
			Had swollen feet or ankles?	[ ] No	[ ] Yes
Difficulty breathing?	[ ] No	[ ] Yes			
Had chest pain or tightness?	[ ] No	[ ] Yes	Had any skin changes? (lumps or lesions or rashes)	[ ] No	[ ] Yes
Had palpitations or fluttering in your chest?	[ ] No	[ ] Yes			
Had frequent coughing?	[ ] No	[ ] Yes	Had new weakness?	[ ] No	[ ] Yes
Had wheezing or been short of breath?	[ ] No	[ ] Yes			
Have you coughed up any blood?	[ ] No	[ ] Yes	Been overly anxious?	[ ] No	[ ] Yes
Had night sweats?	[ ] No	[ ] Yes	Felt sad or depressed?	[ ] No	[ ] Yes
			Heat or cold intolerance?	[ ] No	[ ] Yes
Had snoring or stopped breathing at night?	[ ] No	[ ] Yes	Frequent urination?	[ ] No	[ ] Yes
Had frequent headaches?	[ ] No	[ ] Yes			
Had morning headaches?	[ ] No	[ ] Yes	Had easy bruising or bleeding?	[ ] No	[ ] Yes
			Had seasonal allergies?	[ ] No	[ ] Yes

Name:_____

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Medications: If you have a list, please leave this blank and we will copy your list.

Name of Medication	Dosage	How often

Past Medical History:

Check boxes if you have ever had the following (leave others blank):

- ☐ Heart attack if so, how many years ago? _____
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Pulmonary Hypertension
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Blood Clot
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Nervous or emotional problems
- ☐ Depression
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Bronchitis
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joints
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems

Comments: _____

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Name:_____

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FAMILY HISTORY: Please indicate the current status of your immediate family members: If any of the following Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Lung Disease_____
Cancer, specify type_____
Heart disease_____
Depression/suicide_____
Sleep Disorder (Sleep apnea etc.)_____
Diabetes_____
Arthritic/Rheumatologic_____
High cholesterol_____
High blood pressure_____
Stroke_____
Bleeding or clotting disorder_____
Thyroid problems_____
Alcoholism _____
Other_____

Social Information:

Do you drink alcohol? [ ] Yes [ ] No
Have you ever smoked? [ ] Yes [ ] No How many years_____How many Packs per day?_____

If Yes: Are you still smoking: [ ] Yes [ ] No If No: When did you stop_____

What kinds of work have you done in your lifetime? Please include military service.

_____

_____

_____

1. Do you have animals in the home (or near the home in another building)? [ ] Yes [ ] No

   If Yes: what kinds:_____

2. Have you had a chest xray in another location? [ ] Yes [ ] No

   Where? :_____ _____

3. Have you had a CT scan of your chest ("cat" scan) [ ] Yes [ ] No

   If yes: where? :_____

4. Have you had a pulmonary function test (breathing test) in another location? [ ] Yes [ ] No

   If yes: where? :_____

5. Have you had surgery for your lungs? [ ] Yes [ ] No

   If yes: where? :_____

Is there anything else you think the doctor should know?_____

_____