# NORTHSIDE HOSPITAL    Pulmonary Patient History Form

| PATIENT NAME | | DATE | |
|---|---|---|---|
| **Day Phone** | | **Cell Phone** | |
| **Sex   M   F** | **Date of Birth** | **Height** | **Weight**              **lbs** |
| **Procedure name** | | **Date/time of Procedure** | |
| **Name of Doctor performing procedure** | | | |
| **Primary Language** | | **Preferred Language** | |
| **Do you need an interpreter?** | | | |
| **Emergency Contact** | | **Phone Number** | |
| **Name of patient's driver** | | **Phone Number** | |

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|---|---|---|---|
| Are you pregnant? | | Yes | No |
| Are you experiencing pain?          Yes          No | Location? | Level of pain (1-10) | |
| Do you have a hearing impairment? | | Yes | No |
| If yes, explain | | | |
| Do you have any vision impairments? Including glasses/contacts? | | Yes | No |
| If yes, explain | | | |
| Do you have any mobility impairments? Amputation? | | Yes | No |
| If yes, explain | | | |
| Do you have any denture, caps, broken or loose teeth? | | Yes | No |
| If yes, explain | | | |
| Do you smoke/use tobacco? | | Yes | No |
| Do you drink alcohol? | | Yes | No |
| Do you use recreational drugs? | | Yes | No |
| Do you have implants or prostheses? | | Yes | No |
| If yes, explain | | | |
| Do you have any back, neck, or jaw problems? | | Yes | No |
| If yes, explain | | | |
| Do you have any musculoskeletal conditions? | | Yes | No |
| If yes, explain | | | |
| Do you have asthma? | | Yes | No |
| Do you have bronchitis or COPD? | | Yes | No |
| Do you ever experience shortness of breath? | | Yes | No |
| If yes, explain | | | |
| Do you have sleep apnea? | | Yes | No |

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|---|---|---|
| Do you use a nebulizer, breathing machine or oxygen at home? | Yes | No |
|   If yes, explain | | |
| Do you have high blood pressure? | Yes | No |
| Do you have congestive heart failure? | Yes | No |
| Do you have an irregular heartbeat? | Yes | No |
|   If yes, explain | | |
| Have you had a heart attack? | Yes | No |
| Have you had heart surgery/stent/catheter placement? | Yes | No |
| Do you have a pacemaker/defibrillator? | Yes | No |
| Have you ever had a stroke or TIA? | Yes | No |
| Have you ever had a seizure? | Yes | No |
| Do you have any paralysis? | Yes | No |
|   If yes, explain | | |
| Have you ever been diagnosed with cancer? | Yes | No |
|   If yes, explain | | |
| Do you have diabetes? | Yes | No |

| | | | | | |
|---|---|---|---|---|---|
| Diet controlled? | Yes | No | Insulin Controlled? | Yes | No |

| | | |
|---|---|---|
| Are you hypothyroid? | Yes | No |
| Are you hyperthyroid? | Yes | No |
| Do you have acid reflux? | Yes | No |
| Do you have hepatitis? | Yes | No |
| Do you have any kidney conditions? | Yes | No |
|   If yes, explain | | |
| Are you on dialysis? | Yes | No |
| Do you have any rashes? | Yes | No |
|   If yes, explain | | |
| Do you have any bruises? | Yes | No |
|   If yes, explain | | |
| Do you have any burns? | Yes | No |
|   If yes, explain | | |
| Do you have any wounds? | Yes | No |
|   If yes, explain | | |

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|---|---|---|
| Do you have any problems with tape? | Yes | No |
| If yes, explain | | |
| Do you have sickle cell disease? | Yes | No |
| Do you have any blood clots or have a history of blood clots? | Yes | No |
| Are you taking or have you been taking blood thinners? | Yes | No |
| Did your doctor instruct you to stop taking your blood thinners before your procedure? | Yes | No |
| Do you take ibuprofen regularly? | Yes | No |
| Did your doctor instruct you to stop taking your aspirin/ibuprofen before your procedure? | Yes | No |
| Have you ever been diagnosed with TB? | Yes | No |
| So you have symptoms/signs of TB which include: | | |
| Coughing for more than 3 weeks | Yes | No |
| Loss of appetite | Yes | No |
| Unexplained weight loss, night sweats, bloddy sputum | Yes | No |
| Have you ever been diagnosed with MRSA? | Yes | No |
| Have you ever been diagnosed with VRE? | Yes | No |
| Have you been diagnosed with HIV/AIDS? | Yes | No |
| Have you traveled outside the U.S. recently? | Yes | No |
| If yes, when/where? | | |
| Have you ever been treated for depression? | Yes | No |
| Have you been diagnosed with an anxiety/panic disorder? | Yes | No |
| Have you ever been treated for substance abuse? | Yes | No |

**SURGICAL HISTORY**

| Operation/Procedure | Anesthesia | Complications | Year |
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**CURRENT MEDICATIONS (prescribed, over-the-counter, herbal, steroids, diet pills)**

| Medication | Dosage | How often? |
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