CHEROKEE
LUNG & SLEEP SPECIALISTS
A Northside Network Provider

Name:_____ DOB:_____ Date:_____
First, middle initial, last

Referred by:_____ Primary Care Physician: _____

Have you seen another physician regarding this condition? Yes No

If yes, list names and dates:_____

**Reason for visit:** _____

Chief complaint: _____

Duration of complaint:_____

Trend of symptoms: ☐ Worsening ☐ Improving ☐ Constant ☐ Waxes and wanes ☐ No change
☐ Episodic ☐ Other: _____

## PERSONAL MEDICAL HISTORY

### PULMONARY
☐ Allergies
☐ Alpha 1 Antitrypsin
☐ Asbestosis
☐ Asthma
☐ Recurrent Bronchitis
☐ COPD
☐ Emphysema
☐ Lung Nodule(s)
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Fibrosis
☐ Sarcoidosis
☐ Sleep Apnea
☐ Valley Fever (Coccidioidomycosis)

### RHEUMATOLOGIC
☐ Lupus
☐ Rheumatoid Arthritis

### ENT
☐ Hearing Impaired

### CARDIOVASCULAR
☐ Anemia
☐ Atrial Fibrillation
☐ Blood Clots/DVT
☐ Chest Pain (Angina)
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Elevated Cholesterol
☐ High Blood Pressure (HTN)
☐ Heart Attack (MI)
☐ Murmur/Heart Valve Disease
☐ Stroke

### GASTROINTESTINAL
☐ Acid Reflux (GERD)
☐ Hepatitis, Type: C B A

### GENITOURINARY
☐ Kidney Stones
☐ Chronic Kidney Disease

### MUSCULOSKELETAL
☐ Arthritis
☐ Fibromyalgia
☐ Osteoarthritis
☐ RA

### NEUROLOGIC/PSYCHOLOGICAL
☐ Anxiety
☐ Bipolar Disorder
☐ Dementia
☐ Depression
☐ Epilepsy / Seizures
☐ Headaches
☐ Insomnia
☐ Restless Leg Syndrome

### ENDOCRINE
☐ Autoimmune Disorder
☐ Diabetes, Type: 1 2
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Prednisone use

### OTHER
☐ Cancer, Type:_____
☐ HIV/AIDS
☐ Immunoglobulin Deficiency
☐ Tuberculosis

### PSYCHIATRIC
☐ PTSD
☐ Suicide Attempt

Additional Medical History _____

## SURGICAL HISTORY

### PULMONARY — YEAR
☐ Bronchoscopy _____
☐ Lobectomy: L R _____
☐ Lung Biopsy _____
☐ Lung Surgery _____
☐ Tracheostomy _____

### CARDIOVASCULAR
☐ CABG/Open Heart Surgery _____
☐ Cardiac Catheterization _____
☐ Cardiac Stent _____
☐ Pacemaker _____

### ENT
☐ Adenoidectomy _____
☐ Septoplasty _____
☐ Sinus Surgery _____
☐ Tonsillectomy _____

### GASTROINTESTINAL — YEAR
☐ Appendix Removal _____
☐ Gall Bladder Removal _____
☐ Gastric Bypass _____
☐ Hernia Repair _____

### GENITOURINARY
☐ Dialysis _____
☐ Kidney Stone Removal _____
☐ Kidney Removal _____

### MUSKULOSKELETAL
☐ Back Surgery _____
☐ Hip Replacement: L R _____
☐ Knee Replacement: L R _____
☐ Neck Surgery _____
☐ Rotator Cuff Repair: L R _____

### FEMALE — YEAR
☐ C-Section (Cesarean) _____
☐ Hysterectomy _____
☐ Tubal Ligation _____

### MALE
☐ Prostate Surgery _____

### OTHER
☐ Cataract Surgery _____
☐ LASIK _____
☐ Lymph Node Biopsy _____
☐ Mastectomy _____
☐ Thyroidectomy _____

Additional Surgical History _____

## FAMILY HISTORY

☐ No Significant Family History ☐ Adopted

| | | | | |
|---|---|---|---|---|
| **PULMONARY** | | | | |
| Alpha 1 Antitrypsin | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Asthma | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| COPD | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Emphysema | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Pulmonary Fibrosis | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Pulmonary Hypertension | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Sarcoidosis | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Sleep Apnea | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| **CANCER** | | | | |
| Breast Cancer | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Colon Cancer | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Lung Cancer | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Other Cancer _____ | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| **CARDIOVASCULAR** | | | | |
| Coronary Artery Disease | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Hypertension | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Venous Thrombosis | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| **RHEUMATOLOGIC** | | | | |
| Rheumatoid Arthritis | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Lupus | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| **NEUROLOGICAL** | | | | |
| Alzheimer's | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Dementia | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| **ENDOCRINE** | | | | |
| Diabetes | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| **SOCIAL** | | | | |
| Alcoholism | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |
| Drug Abuse | ☐ Father | ☐ Mother | ☐ Brother | ☐ Sister |

Additional Family History _____

## SOCIAL HISTORY

**Do you use Tobacco:** Yes No Former **Type of Tobacco:** Cigarettes Cigar Pipe Chew Smokeless
**Overall Daily Average:** _____ packs(s)/pipe/can **Total # of Years Used:** _____ **Date Quit:** _____

**Do you drink Alcohol:** Yes No Former **Type of Alcohol:** Beer Wine Liquor **How Much:** _____ Beers/Glasses/Drinks
**Date Quit:** _____ **How Often:** Daily Weekly Monthly Yearly

**Do you drink Caffeine:** Yes No **Type of Caffeine:** Coffee Tea Soda Energy drinks **How Much:** _____ cups/ounces

**Do you use Recreational drugs:** Yes No Former **Type:** _____ **How Often:** Daily Weekly Yearly **Date Quit:** _____

**Do you use Exercise:** Yes No **Type of Exercise:** _____ **How Much:** _____ **How Often:** Daily Weekly Monthly

**Occupation:** _____ **Marital Status:** Single Married Life Partner Divorced Widowed
**Domestic Partner:** Opposite Sex Same Sex **# of Children:** ____ Sons ____ Daughters **Pets:** Yes No **Type:** _____

| |
|---|
| Do you have an Advance Directive or Living Will? |
| Would you like information on the preparation of these? |

Patient/Guarantor Signature: _____ Date: _____

CHEROKEE
LUNG & SLEEP SPECIALISTS
A Northside Network Provider

# MEDICATION LIST

Name:_____ DOB:_____ Date:_____
First, middle initial, last

Pharmacy:_____ Location _____ Phone Number (_____) _____

Any **allergies** to medicines: Yes No Unknown

If Yes, what medicine(s):_____ What reaction(s):_____

_____ _____

**PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICINES, VITAMINS AND SUPPLEMENTS**

| Medication Name | Strength (mg, mcg, etc.) | How Often (1 x day, 2 x day, etc.) | Reason for taking (heart, blood pressure, etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Immunizations: | | | |
|---|---|---|---|
| Influenza **(FLU)** | Date: | ☐ Yes | ☐ No |
| Pneumococcal / Prevnar | Date: | ☐ Yes | ☐ No |