TMH PHYSICIAN PARTNERS

TMH PHYSICIAN PARTNERS -
PULMONARY, CRITICAL CARE, SLEEP SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________ **Today's Date:** _______________________

Date of Birth: ______________________ **Age:** __________ **Height:** _________ **Weight:** _______

Reason for today's visit?____

Please <u>check</u> any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-Stroke)
[ ] Asthma
[ ] COPD or Emphysema
[ ] Obstructive Sleep Apnea
[ ] Coronary Artery Disease
[ ] Congestive Heart Failure
[ ] Atrial Fibrillation
[ ] Chronic Sinus Problems
[ ] Glaucoma
[ ] Pneumonia
[ ] Depression/Anxiety
[ ] Gastric Reflux
[ ] Liver Disease
[ ] Kidney Disease
[ ] Prostate Problems
[ ] Hepatitis
[ ] Bleeding/Clotting Problems
[ ] Abnormal Heart Rhythm
[ ] Thyroid Disease
[ ] Seizure Disorder
[ ] Chronic Pain
[ ] Sleep Disorder
[ ] Bipolar Disease
[ ] HIV/AIDS
[ ] Diabetes
[ ] Cancer _________________
[ ] Anemia
Other: ____________________

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Family History: Please check the following health problems that have affected your family and identify their relationship to you, ie: Mother, father, grandparent, sibling, child.

[ ] Adopted
[ ] Blood Clots __________
[ ] Bleeding Problems __________
[ ] High Blood Pressure __________
[ ] High Cholesterol __________
[ ] Thyroid Problems __________
[ ] Heart Attack __________
[ ] Diabetes __________
[ ] Cancer __________
[ ] Lung Disease __________
[ ] Asthma __________
[ ] Dialysis __________

Have you used tobacco? [ ] No [ ] Yes; If yes, packs/ day: __________ Year Quit: __________

Do you drink alcohol? [ ]No [ ]Yes; If yes, drinks per day __________ Per week: __________

Do you use recreational drugs? [ ]No [ ]Yes; If yes , describe: ____

Have you worked with asbestos products? [ ] No [ ] Yes; If yes, describe the job ____________________________________

Have you been exposed to tuberculosis? [ ] No [ ] Yes; If yes, please describe _____________________________________

Last PPD Date; ______________ Results: [ ] Normal [ ] Abnormal

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Patient Name: ______________________________ **Date of Birth:** ____

List Drug, Food, or Substance Allergies & Reactions:

____

____

____

Preferred Pharmacy: _________________________________ Pharmacy Location: ________________________________

Complete your medication list to the best of your ability:

Date	**Drug**	**Dose**	**Frequency**	**Indication**

*** Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.

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PATIENT SCREENING AND ASSESSMENT

****Please complete entire form **including date, name, and date of birth******

Date____________Name____DOB_____________

If you have had the following vaccines please document the dates given:

Flu___________ Shingles___________ Pneumovax___________ Prevnar___________

Have you lost interest in doing things that used to give you pleasure?
{ } Not at all { } Several days { } More than half days { } Nearly every day

Have you been feeling down, depressed or hopeless in the past 2 weeks?
{ } Not at all { } Several days { } More than half days { } Nearly every day

Have you experienced 10 pounds weight loss in the last 3 months?
{ } No { } Yes

Have you experienced 10 pounds weight gain in the last 3 months?
{ } No { } Yes

History of falling in the last 3 months?
{ } No { } Yes

Impaired judgment/lack of safety awareness?
{ } No { } Yes

Agitation?
{ } No { } Yes

Impaired gait, shuffle, wide base, unsteady walk?
{ } No { } Yes

Ever experienced dizziness or vertigo?
{ } No { } Yes

Ever wet or soil yourself on way to bathroom?
{ } No { } Yes

Are you in a relationship where you are being threatened or hurt?
{ } No { } Yes

Date________________ **Name**______________________________ **DOB**________________

Please select those symptoms you are currently experiencing regulary.

CONSTITUTIONAL SYMPTOMS
{ } Good general health
{ } Recent weight loss
{ } Excessive daytime sleepiness
{ } Snoring
{ } Fevers
{ } Fatigue
{ } Night sweats

EYES
{ } Double vision
{ } Blurred vision

EAR, NOSE, THROAT & MOUTH
{ } Ringing in the ears
{ } Difficulty hearing
{ } Chronic sinus drainage
{ } Frequent sneezing
{ } Swollen glands
{ } Change in voice (hoarseness)

PULMONARY
{ } Chronic cough
{ } Shortness of breath
{ } Wheezing
{ } Blood in sputum
{ } Pain with breathing

CARDIOVASCULAR
{ } Chest pains
{ } Palpitations (heart racing)
{ } Swelling of feet

GASTROINTESTINAL
{ } Heartburn
{ } Nausea or vomiting
{ } Poor appetite
{ } Change in bowel movements
{ } Diarrhea
{ } Constipation
{ } Blood in stool

NEUROLOGICAL
{ } Morning headaches
{ } Migraine Headaches
{ } Dizziness
{ } Seizures
{ } Poor memory
{ } Tremors
{ } Weakness

HEMATOLOGICAL/LYMPHATIC
{ } Easy bruising
{ } Excessive bleeding
{ } Enlarged gland/lymph nodes

MUSCULOSKELETAL
{ } Joint pains
{ } Joint stiffness
{ } Joint swelling
{ } Difficulty walking
{ } Back pain

GENITOURINARY
{ } Frequent urination
{ } Burning urination
{ } Urinary incontinence
{ } Blood in urine
{ } Males: Testicular pain
{ } Female: Vaginal discharge

INTEGUMENTARY (SKIN/BREASTS
{ } Itching or rash
{ } Varicose veins
{ } Change in skin color
{ } Abnormality in nails/hair
{ } Breast pain
{ } Nipple discharge

PSYCHIATRIC
{ } Depression
{ } Mood swings
{ } Increased irritability
{ } Difficulty concentrating
{ } Nervousness/anxiety
{ } Insomnia

ENDOCRINE
{ } Excessive thirst
{ } Poor control of blood sugar
{ } Intolerance to heat
{ } Intolerance to cold

ALLERGIC/IMMUNOLOGIC
{ } Nasal allergies/hay fever
{ } Recurrent hives

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Date______________ Name____DOB____________

EPWORTH SLEEPINESS SCALE

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation below:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation:	**Chance of dozing (please circle one)**			
Sitting & reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place for an hour without a break	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total score ______________

(Maximum- 24, normal <10)