Patient Name: _____

Date of Birth: _____

Cell Phone: (_____) _____

Emergency Contact Phone: (_____)_____

Physician and Pharmacy Information

(Please check the box next to your referring physician.)

Primary Care Physician (Family Practice, Internist)

Name _____

Address _____

_____

_____

Phone _____

Fax

Email

Physician #2 (Pulmonology, Allergy, Cardiology, GI)

Name _____

Address _____

_____

_____

Phone _____

Fax

_____

_____

_____

_____

Phone _____

Fax _____

Email _____

_____

_____

_____

_____

Phone _____

Fax _____

Email _____

Preferred Retail Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

"

Mail Order/Alternate Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Medical History: What would you like to talk about during your visit?

Medications Taken Regularly

Include all herbal medications, supplements, vitamins and over-the-counter medications. If needed, please provide a separate list.

	Medication Name	Dose	Route (Oral, Inhale)	How Often?
ex	*Lipitor*	*10 mg*	*oral*	*Once daily*

;"""""""""""""""""#$‰'(%")$*''"++"""",'-ℓ.$/"0'.12-")3*4'2+++++++++++++++++++++++++++++"""""""""""""""56#2'!"7!!8!9:"
"

Past Surgical History

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

9"""""""""""""""#$‰'(%")$*'"++"""",'-ℓ.$/"0'.12-")3*4'2+++++++++++++++++++++++++++++"""""""""""""""56#2'!"7!!8!9:"
"

Social History

1. Smoking History: I have **never** s2

="""""""""""""""#$‰'(%")$*'"++""" , '-ℓ.$/"0'.12-")3*4'2+++++++++++++++++++++++++++""""""""""""""56#2'!"7!!8!9:"
"

Health Maintenance:

1. **Exercise**: Do you exercise regularly? Yes No Minutes/week: _____

2. **Vaccination/Immunization History**

Vaccine/Immunization			Date of last vaccination/immunization
Flu (Influenza)	Yes	No	
Pneumonia	Yes	No	
Tetanus	Yes	No	
BCG	Yes	No	
Chicken Pox (Varicella) If no, have you had chicken pox?	Yes Yes	No No	
Shingles	Yes	No	
HPV (Gardasil)	Yes	No	
tDAP (Pertussis, **list others**)?			

>"""""""""""""""#$‰'(%")$*'"++"""",'-ℓ.$/"0'.12-")3*4'2+++++++++++++++++++++++++++"""""""""""""""56#2'!"7!!8!9:"
"

Asthma Symptoms

!"#$%&'()*#+),'-."#'

/)+'.&0$'12."#3)*4'5,.&".'&*"6.+'63#$'7894'2"3*:'#$.';."0+35#3)*""<.,)6'#$.'12."#3)*='

In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school, or at home?	1 2 3 4 5

1. All of the time; 2. Most of the time; 3. Some of the time; 4. A little of the time: 5

A"""""""""""""""#$‰'(%")$*'"+++"""",'-ℓ.$/"0'.12-")3*4'2

ILD/Pulmonary Fibrosis Symptoms"

A A B ('@C"5*.&'D0)+.'

?,.&".'Check'#$.')*.'<."#'+."5)*".'#)';."0+3<.'C)2+'"$)+#*."""')E'<+.&#$'

F+&;.'

B