NORTHERN VIRGINIA PULMONARY AND CRITICAL CARE ASSOCIATES, P.C.

BOARD CERTIFIED, PULMONARY DISEASE
BOARD CERTIFIED, CRITICAL CARE MEDICINE
**BOARD CERTIFIED, SLEEP MEDICINE*

Robert Bloom, M.D.
Thomas A. McCabe, M.D.*
James P. Lamberti, M.D.
Ellen C. Vaughey, M.D.

Eric A. Libré, M.D.
Matthew D. Williams, M.D.
Adlah Sukkar, M.D.
Mark Granada, M.D.

Date: ________________

Patient Name: ________________________________ **Acct #:** ________________

Patient DOB: ________________________

Past Medical History

- ☐ AIDS/HIV disease
- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer ________________________________
- ☐ Date of last Chest X-ray
- ☐ Diabetes Mellitus, Type I
- ☐ Diabetes Mellitus, Type II
- ☐ Emphysema
- ☐ Exposure to TB
- ☐ G.E.R.D.
- ☐ Heart Disease
- ☐ Hiatal Hernia
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Liver disease
- ☐ Obstructive Sleep Apnea
- ☐ Pneumonia
- ☐ Positive TB skin test in past
- ☐ Pregnant
- ☐ Raynaud's Disease
- ☐ Respiratory Failure, Chronic
- ☐ Rhinitis, Chronic
- ☐ Sleep Apnea, Unspecified
- ☐ Thyroid Disorder
- ☐ Ulcers

Past Surgical History

- ☐ Heart
- ☐ Lung
- ☐ Other ________________________________

Write Details Below:

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Date: ________________

Patient Name: ________________________________ **Acct #:** ________________

Patient DOB: ________________________

Medications

(Include inhaled medications, oxygen, and CPAP or BIPAP useage)

Medication	Dose	Dose Intervals (once a day, 2x a day, etc).

Allergies

Medication/ Misc.	Reaction:

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Date: ________________

Patient Name: ________________________________ **Acct #:** ________________

Patient DOB: ________________________

Medications Continue

(Include inhaled medications, oxygen, and CPAP or BIPAP useage)

Medication	Dose	Dose Intervals (once a day, 2x a day, etc).

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Date: ______________

Patient Name: ______________________________ **Acct #:** ______________

Patient DOB: ______________________

Family History

Check what disease run in your family and specific relative?

- ☐ Emphysema ____________________
- ☐ Multiple Sclerosis ____________________
- ☐ Wegene'rs Granuloma ____________________
- ☐ Anemia ____________________
- ☐ Arthritis ____________________
- ☐ Asthma ____________________
- ☐ Breast Cancer ____________________
- ☐ Bronchiectasis ____________________
- ☐ Bronchitis ____________________
- ☐ Clotting disorder ____________________
- ☐ Colon Cancer ____________________
- ☐ Cystic Fibrosis ____________________
- ☐ Diabetes ____________________
- ☐ Heart Disease ____________________
- ☐ Hemophilia ______________
- ☐ Leukemia ______________
- ☐ Lung Cancer ______________
- ☐ Lupus ______________
- ☐ Malignant Neoplasm ______________
- ☐ Ovarian Cancer ______________
- ☐ Rheumatoid Arthritis ______________
- ☐ Sarcoidosis ______________
- ☐ Scleroderma ______________
- ☐ Sickle Cell Anemia ______________
- ☐ Stroke ______________
- ☐ Thromboembolic ______________
- ☐ Tracheal Cancer ______________
- ☐ Tuberculosis ______________

Write Details Below:

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Date: ______________

Patient Name: ____________________________ **Acct #:** ______________

Patient DOB: ____________________

Social History

Abestos Exposure yes no
Do you keep animals at home? yes no
Dust Exposure yes no
Employment Status: ________________
Occupation: ________________
Strong Chemicals Exposure yes no
Traveled in last year? ________________ (list places and dates)
Tobacco use? yes no Never

- ☐ Current smoker Average packs/day ______ Number of years smoking ________
- ☐ Quit When? ____________ Average packs/day ______ Number of years ________

Approximately how many drinks of alcohol do you have per week? ____________________

Birthplace: __________________

Write Details Below:

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Date: ______________________

Patient Name: ____________________________ **Acct #:** ______________________

Patient DOB: ______________________

Review of Symptoms

Other than your breathing problem, please check and describe problems you have experienced in the past three (3) months

CONSTITUTIONAL
- ☐ Fever
- ☐ Loss of appetite
- ☐ Chills
- ☐ weight loss of more than 5 pounds
- ☐ weight gain of more than 5 pounds
  How much? ______________________
  (unexplained weigh loss/gain)
- ☐ Night Sweats
- ☐ Malaise (Unusual fatigue)

EYES
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye discomfort (irritation)
- ☐ Changes in vision
- ☐ Blurred vision

HENT
- ☐ Headaches
- ☐ Hearing difficulty (loss)
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Vertigo (unusual dizziness)
- ☐ Sinus pain
- ☐ Nasal Discharge
- ☐ Tinnitus (ringing ears)
- ☐ Lighteadness/fainting
- ☐ Nasal Congestion
- ☐ Postnasal Drip
- ☐ Ear pain

BREASTS
- ☐ Lumps
- ☐ Breast discomfort

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular heart beats
- ☐ Dyspnea on extertion
- ☐ Lower extremity edema (swelling at ankles)
- ☐ Rapid heart rate
- ☐ *Heart murmur*

RESPIRATORY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Chest Wall Pain

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Reflux (gastro esophageal)
- ☐ Nausea
- ☐ Constipation
- ☐ Heartburn
- ☐ Diarrhea

GENITOURINARY
- ☐ Urgency (Frequent urination)
- ☐ Hematuria (blood in urine)
- ☐ Irregular Menses (irregular menstrual periods or vaginal bleeding)
- ☐ Dysuria (painful urination)

INTEGUMENT
- ☐ Rash
- ☐ Skin dryness
- ☐ Itching

NEUROLOGIC
- ☐ Tingling or numbness
- ☐ Altered mental status/ loss of consciousness
- ☐ Seizures
- ☐ *Sleepiness in the daytime*

MUSCULOSKELETAL
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Neck pain
- ☐ Back pain
- ☐ *Fingers turn white & painful of cold*
- ☐ *Morning stiffness*

ENDOCRINE
- ☐ Polyuria (Excessive urination)
- ☐ Polydipsia (Excessive thirst)

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐

HEME-LYMPH
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ lymp node enlargement

- ☐ Other Symptoms: ______________________ ______________________

- ☐ No Other Symptoms

Additonal Comments:

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Date: ________________________

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Patient DOB: ________________________

Pulmonary History

Check all that currently apply

- ☐ Intermittent cough (not related to a common cold)
- ☐ Frequent cough in the morning
- ☐ Sputum production: _______ tablespoons per day
- ☐ Coughing up blood
- ☐ Chest congestion/tightness

- ☐ Daytime sleepiness
- ☐ Postive TB skin test in the past
- ☐ Exposure to TB
- ☐ Pneumonia Date: _______________

Shortness of breath

- ☐ During strenuous exercise
- ☐ During moderate exercise
- ☐ During normal activity
- ☐ While at rest
- ☐ Awaken at night

Wheezing:

- ☐ Following a common cold
- ☐ With exercise
- ☐ Seasonally (spring/fall)
- ☐ Snoring

How many blocks on level can you walk? ________________________
How many flights of stairs can you climb? ________________________
Date of last Chest X-Ray ________________________
Pneumococcal pneumonia vaccine-date ________________________
Influenza vaccine-date ________________________

Write Details Below:

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