THE UNIVERSITY OF KANSAS PHYSICIANS

Department of Internal Medicine – Pulmonary

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Name: _____
KUMC #: _____
Date: _____ **DOB**: _____

Medical History:

Do you have a living will or advance directive? **Yes___ No___**
Is it a part of your UKP Medical Record? **Yes___ No___**

Please circle if history of:

Asthma	Cystic Fibrosis	Obstructive Sleep Apnea
Autoimmune Disease	Diabetes Mellitus	Occupational Lung Disease
Bronchiectaisis	Deep Vein Thrombosis	Pneumonia
Cancer	Home Oxygen Use	Pulmonary Embolism
Chronic Bronchitis	Hypertension	Pulmonary Fibrosis
Chronic Lung Disease	Inflammatory Arthritis	Pulmonary Hypertension
Chronic Sinusitis	Lung Cancer	Seasonal Allergies
COPD	Neuromuscular Disease	Tuberculosis
Coronary Artery Disease		

Surgical History:

Please circle if history:

Bronchoscopy	Cardiac Catheterization	Pacemaker
CABG	Lung Surgery	Tracheostomy

Past Hospitalizations:

Date	**Hospital**	**Length of Stay**	**Diagnosis**

Family History:

	Relationship (Mother, Father, Sister, Brother, Daughter, Son)
Asthma:	_____
Blood Clots:	_____
Cancer:	_____
COPD:	_____
Coronary Artery Dis:	_____
Cystic Fibrosis:	_____
Deep Vein Thrombosis:	_____
Pulmonary Embolism:	_____
Pulmonary Fibrosis:	_____
Pulmonary HTN:	_____

Social History:

Tobacco Use Yes_____ No_____
If you are currently a smoker, how many packs a day do you smoke? _____
If you are a former smoker when did you quit? _____
Are you a Smokeless Tobacco user? _____
If you are a former Smokeless Tobacco user when did you quit? _____

Alcohol Use Yes_____ No_____
Drinks/Week: Glasses of Wine_____
Cans of Beer_____
Shots of Liquor_____
Drinks containing 0.5 oz of alcohol_____

Drug Use Yes_____ No_____
Types Marijuana_____ Times per week_____
Methamphetamines_____ Times per week_____
Cocaine_____ Times per week_____
IV_____ Times per week_____
Heroin_____ Times per week_____
PCP_____ Times per week_____
Other_____ Times per week_____

Sexually Active Yes_____ No_____ Partners Female_____ Male_____
Not Currently_____

Occupation:
Employer_____

Position_____

Marital Status_____
Spouse name_____

Number of Children_____
Years of education_____

Pulmonary Exposure History:
Asbestos Exposure? Yes_____ No_____
Occupational Exposure to Hazardous Materials? Yes_____ No_____
If yes, exposure to what? _____
How many years of exposure? _____
Last know exposure?_____

Pets in the Home:
Birds Yes____No _____ Cats Yes____No_____ Dog Yes____No_____
Rodent Yes____No_____ Other Yes ____No____ Explain _____

Review of Systems. Please check the symptoms you are ***currently*** experiencing.

CONSTITUTION	EYES	ENDOCRINE	ALLERGY/IMMUNOLOGY
☐ Activity change	☐ Eye discharge	☐ Cold intolerance	☐ Environmental allergies
☐ Appetite change	☐ Eye itching	☐ Heat intolerance	☐ Food allergies
☐ Chills	☐ Eye pain	☐ Excessive thirst (Polydipsia)	☐ Immunocompromised
☐ Diaphoresis (Sweating)	☐ Eye redness	☐ Increased appetite (Polyphagia)	**NEUROLOGICAL**
☐ Fatigue	☐ Sensitivity to light (Photophobia)	☐ Excessive urination volume (Polyuria)	☐ Dizziness
☐ Fever	☐ Visual disturbances	**GENITOURINARY**	☐ Facial asymmetry
☐ Unexpected weight change	**RESPIRATORY**	☐ Difficulty urinating	☐ Headaches
HEAD/ENT	☐ Apnea	☐ Painful intercourse (Dyspareunia)	☐ Light-headedness
☐ Congestion	☐ Chest tightness	☐ Painful urination (Dysuria)	☐ Numbness
☐ Dental problem	☐ Choking	☐ Incontinence (Enuresis)	☐ Seizures
☐ Drooling	☐ Cough	☐ Flank pain	☐ Speech difficulty
☐ Ear discharge	☐ Shortness of breath	☐ Frequency	☐ Fainting (Syncope)
☐ Ear pain	☐ Inhale wheeze (Stridor)	☐ Genital sore	☐ Tremors
☐ Facial swelling	☐ Wheezing	☐ Blood in urine (Hematuria)	☐ Weakness
☐ Hearing loss	**CARDIOVASCULAR**	☐ Menstrual problem	**HEMATOLOGIC**
☐ Mouth sores	☐ Chest pain	☐ Pelvic pain	☐ Enlarged lymph node (Adenopathy)
☐ Nosebleeds	☐ Leg swelling	☐ Urgency	☐ Bruises/bleeds easily
☐ Postnasal drip	☐ Palpitations	☐ Urine decreased	**PSYCHIATRIC**
☐ Rhinorrhea (Runny Nose)	**GASTROINTESTINAL**	☐ Vaginal bleed	☐ Agitation
☐ Sinus pressure	☐ Abdominal distension	☐ Vaginal discharge	☐ Behavior problem
☐ Sneezing	☐ Abdominal pain	☐ Vaginal pain	☐ Confusion
☐ Sore throat	☐ Anal bleeding	**MUSCULOSKELETAL**	☐ Decreased concentration
☐ Tinnitus (Ringing in ear)	☐ Blood in stool	☐ Joint pain (Arthralgias)	☐ Dysphoric mood
☐ Trouble swallowing	☐ Constipation	☐ Back pain	☐ Hallucinations
☐ Voice change	☐ Diarrhea	☐ Gait problem	☐ Hyperactive
	☐ Nausea	☐ Joint swelling	☐ Nervous/anxious
	☐ Rectal pain	☐ Muscle pain (Myalgias)	☐ Self-injury
	☐ Vomiting	☐ Neck pain	☐ Sleep disturbance
		☐ Neck stiffness	☐ Suicidal thoughts
		SKIN	
		☐ Color change	
		☐ Pale skin	
		☐ Rash	
		☐ Wound	