

ALLERGIES TO MEDICATIONS:

(describe type of reaction or side effect)

PULMONARY HEALTH MAINTENANCE:

Have you received the pneumonia vaccine (Pneumovax)?

Date: _____

Have you received the influenza vaccine (flu shot)?

Date: _____

SOCIAL HISTORY:

(Check box or fill out information)

Marital Status (S) (M) (D) (W)

Smoking History (No) (Yes)

Start (year): _____

Quit (year): _____

Average pack(s) per day: _____

Exercise: (describe activity per week)

Drinking: (specify type of alcohol and ounces per day)

ENVIRONMENTAL AND OCCUPATIONAL HISTORY:

Current occupation:

Prior type of employment:

Dust exposure: (None) (Yes)

Start (year): _____

Quit (year): _____

Asbestos exposure: (None) (Yes)

Duration of exposure: _____

Type of work: _____

Quit (year): _____

Mining: (None) (Yes)

Start (year): _____

Sandblasting: (None) (Yes)

Start (year): _____

Household birds: (None) (Yes)

Describe: _____

Hot tub or sauna: (None) (Yes)

Describe: _____

Household molds: (None) (Yes)

Describe: _____

Other: (None) (Yes)

Describe: _____

UT Southwestern Medical Center
 Aston Ambulatory Care Center
 Patient Review of Systems
 Pulmonary Diseases

REVIEW OF SYSTEMS

(Check the box next to the symptoms that you have noticed over the last year; leave blank if none apply)

___ Constitutional

No complaints	___	Weight Loss	___	Fever	___	Chills	___
Poor appetite	___	Weight gain	___	Fatigue	___	Snoring	___
Night sweats	___	Malaise	___	Apnea	___	Choking	___
Always tired	___	AM Headaches	___	Blackouts	___		
Restful sleep	___	Sleepiness	___	Dizziness	___		
Hot flashes	___						

Other/Comments: _____

___ Eyes/Head

No complaints	___	Seeing spots	___	Itchy eyes	___
Vision changes	___	Watery eyes	___	Headaches	___
Double vision	___				

Other/Comments: _____

___ Ear/Nose/Throat

No complaints	___	Ringing ears	___	Ear pain	___
Hearing loss	___	Nasal congestion	___	Nasal drainage	___
Nasal polyps	___	Nose bleed	___	Sneezing	___
Change smell	___	Hoarseness	___	Bad breath	___
Sinus pain	___	Change in taste	___		
Sore throat	___				

Other/Comments: _____

___ Respiratory

No complaints	___	Pneumonia	___	Phlegm	___
Cough	___	Chest injury	___	Pleurisy	___
Chest tightness	___	Wheezing	___		
Coughing blood	___			Exposure to tuberculosis	___
Shortness of breath at rest	___				
Shortness of breath with walking	___				

Other/Comments: _____

___ Heart

No complaints	___	Leg swelling	___	Heart skipping	___
Chest pain	___	Passing out	___	Heart fluttering	___
Heart murmur	___	Waking up short of breath	___		
Palpitations	___				
Shortness of breath while laying flat	___				

Other/Comments: _____

___ Gastrointestinal

No complaints	___	Nausea	___	Vomiting	___
Indigestion	___	Constipation	___	Belly pain	___
Bowel changes	___	Heartburn	___	Choking on food	___
Bloody stools	___	Pain swallowing	___		
Diarrhea	___	Tar-colored stools	___		
Acid taste in mouth	___				

Other/Comments: _____

___ Genitourinary

No complaints	___	Frequent urination	___	Burning with urination	___
Bloody urine	___	Urination at night	___	Recent mammogram	___
Inconsistence	___	Vaginal discharge	___	Abnormal periods	___
Recent pap smear	___			Decrease in urine flow	___

Other/Comments: _____

___ Endocrine

No complaints ___
Excessive thirst ___
Heat intolerance ___

Frequent urination ___
Cold intolerance ___

Increased appetite ___

Other/Comments: _____

___ Musculoskeletal

No complaints ___
Arthritis ___
Joint stiffness ___

Muscle pain ___
Osteoporosis ___

Muscle weakness ___
Back pain ___

Other/Comments: _____

___ Skin/Breast

No complaints ___
Easy bruising ___
Hair loss ___
Discoloring ___
Breast lump ___

Nail changes ___
Hives ___
Boils ___
Nipple discharge ___

Warts ___
Moles ___
Rash ___
Acne ___
Itching ___
Lesions ___

Other/Comments: _____

___ Neurological

No complaints ___
Epilepsy ___
Tingling ___
Headaches ___
Memory problems ___

Seizures ("fits") ___
Speech changes ___
Poor balance ___
Lack of concentration ___

Paralysis ___
Numbness ___
Tremors ___

Other/Comments: _____

___ Psychiatric

No complaints ___
Anxious ___
Mood swings ___
Hallucinations ___

Depressed ___
Hyperactive ___
Developmental delay ___

High stress ___
Irritable ___

Other/Comments: _____

___ Heme/Lymph

No complaints ___
Anemia ___
Hemophilia ___

Easy bruising ___
Easy bleeding ___

Swollen glands ___
Sickle cell dz ___

Other/Comments: _____

___ Allergy/
Immunology

No complaints ___
Nasal drainage ___
Allergy shots ___
Frequent infections ___

Crusting ___
Lupus ___
Autoimmune disease ___

Seasonal allergies ___
Frequent colds ___

Other/Comments: _____

Physician Review:

I have reviewed and discussed the Patient History and Review of Systems with the patient and/or patient's family.

Physician signature: _____

Date: _____