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New Castle	1000 North 16th, Suite 240A	New Castle, IN 47362	ph 765•521•1461	

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Pulmonary History Form

Name: _____ Date: _____

Referring Physician: _____ Date of Birth: _____

Medical History: Please check any of the conditions that represent a SIGNICANT problem for you.

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain w/activity		Frequent urination	
Recent weight changes		Heart skips beats		Night time urination	
Fatigue		Heart beats too fast		Blood in urine	
Heat or cold intolerance		Feet or ankle swelling		Incontinence or dribbling	
Loss of appetite		Calf pain or tenderness		Change in stream	
Head and Neck	YES	Lungs	YES	Irregular menses (female only)	
Swelling in neck		Cough		Gastrointestinal	YES
Pain or stiffness in neck		Cough with sputum or blood		Rectal bleeding	
Skin	YES	Shortness of breath at rest		Blood in stool	
Change in skin color		Shortness of breath during walking or exercise		Chronic abdominal pain	
Rashes or dryness		Chest pain with breathing		Heartburn or indigestion	
Bleeding, bruising tendencies		Wheezing		Constipation or diarrhea	
Eyes	YES	Musculoskeletal	YES	Black or tarry stools	
Double or failing vision		Swollen or red joints		Nausea or vomiting	
Dry eyes		Arm or leg weakness		Vomiting blood	
Pain or light sensitivity		Difficulty walking		Endocrine	YES
Ears, Nose Mouth		Neurologic	YES	Night sweats	
Prolonged hoarseness		Light headed or dizziness		Excessive thirst	
Sore throat		Convulsions or seizures		Psychiatric	
Loss of smell		Numbness or tingling		Depression	
Nose bleeds		Frequent headaches		Anxiety	
Runny or stuffy nose		Memory loss		Anorexia or bulimia	
Earache or drainage		Snoring		Alcohol problems	
Hearing loss/ringing in ears		Sleepiness		Physical, verbal or sexual abuse	
Sores in mouth		Sleep apnea (Stop breathing)		Drug problems	

If you answered yes to any of the above, please explain:

Past and Family Medical History: Please check if you or your family have ever had any of the following:

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Kidney Disease			Vision Problems		
Psoriasis			Blood Disorders			Hearing Problems		
Stroke			Lupus			Low back pain		
Gout			Glaucoma			Other		

