Department of Internal Medicine **Phone: (614) 293-4925**
Pulmonary, Allergy, Sleep and Critical Care **FAX: (614) 293-5503**

OSU Lung Center

The Physicians of the Ohio State University Lung Center are pleased that you will be visiting our offices. In order to best serve your medical needs, would you take amoment to complete the following form, which will provide information that will assist us in your evaluation. Please bring these pages with you for your visit.

Name ☐ Age ☐ Date of Birth ☐

Primary Care or Family Doctor ☐

Referring Doctor (if different) ☐

Please check if you have any of the following symptoms:

Symptom			Symptom		
Cough	☐ No	☐ Yes	Chest pain when breathing	☐ No	☐ Yes
Coughing up blood	☐ No	☐ Yes	Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes	Short of breath with exercise	☐ No	☐ Yes
Sputum Production	☐ No	☐ Yes	Short of breath when laying flat	☐ No	☐ Yes

What triggers your breathing symptoms?

- ☐ animals ☐ tobacco smoke ☐ dust ☐ pollens and mold
- ☐ cold air ☐ exercise ☐ aspirin ☐ air pollution
- ☐ perfumes ☐ paints/solvents ☐ other: ☐

What time of day are your breathing symptoms the worst? ☐

Do you awaken from sleep with breathing problems? ☐ No ☐ Yes

Have you ever gone to the emergency room with breathing problems? ☐ No ☐ Yes

Have you ever been on a mechanical ventilator (respirator)? ☐ No ☐ Yes

Did you have asthma or other lung disease as a child? ☐ No ☐ Yes

Medical History:

1) Please check any medical illness for which you have been previously treated:

☐ Emphysema/COPD	☐ heart attack or MI	☐ cancer	☐ stroke or TIA
☐ asthma	☐ high cholesterol	☐ lung mass	☐ HIV
☐ sarcoidosis	☐ diabetes	☐ reflux / hiatal hernia	☐ chronic anxiety
☐ pulmonary fibrosis	☐ CHF (heart failure)	☐ peptic ulcers	☐ depression
☐ tuberculosis (TB)	☐ high blood pressure	☐ liver disease	☐ chronic pain
☐ obstructive sleep apnea	☐ peripheral vascular disease	☐ thyroid disease	☐ epilepsy or seizures
☐ sinus problems		☐ kidney disease	
		☐ arthritis	

List any other medical illnesses you have:

2) Please list any surgeries you have had and their approximate dates:

3) Please list any hospitalizations you have had and their approximate dates:

4) List any prescribed or over the counter (herbals, vitamins) medicines you are presently using:

Medicine	Dose	Times a day	Medicine	Dose	Times a day

Are you having any trouble affording your medicines? ☐ No ☐ Yes

4) List any medications you are allergic to and the reaction you have had:

Medicine	Reaction	Medicine	Reaction

Do you get a yearly influenza vaccine? ☐ No ☐ Yes

Have you ever been had a pneumococcal vaccine? ☐ No ☐ Yes If yes, date?

Have you ever had a tuberculosis skin test (PPD)? ☐ No ☐ Yes If yes, date?

If yes: was it ☐ Negative ☐ Positive

Family History:

	Age:	Deceased?		Medical illness or cause of death:
Father		☐ No	☐ Yes	
Mother		☐ No	☐ Yes	
☐ Brother ☐ Sister		☐ No	☐ Yes	
☐ Brother ☐ Sister		☐ No	☐ Yes	
☐ Brother ☐ Sister		☐ No	☐ Yes	
☐ Brother ☐ Sister		☐ No	☐ Yes	
☐ Brother ☐ Sister		☐ No	☐ Yes	
☐ Brother ☐ Sister		☐ No	☐ Yes	

Social History:

What is your current job/occupation?

What previous jobs have you had?

Have you ever been in the military? ☐ No ☐ Yes If yes, which branch? What was your role?

Are you: ☐ single ☐ married ☐ widowed ☐ divorced

Please list the ages of any children you have:

What are your current hobbies?

Do you have now or in the past any of the following habits?

Smoking Currently? ☐ No ☐ Yes packs a day for years.

Smoking in past? ☐ No ☐ Yes packs a day for years.

Second-hand smoke? ☐ No ☐ Yes years.

Drink alcohol? ☐ No ☐ Yes drinks per day.

Illicit drugs? ☐ No ☐ Yes ☐ smoked ☐ injected ☐ snorted

Risk for AIDS? ☐ No ☐ Yes ☐ blood transfusion ☐ unprotected sex ☐ other

Exposures:

Do you have animals in your home now? ☐ Dog ☐ Cat ☐ Bird ☐ Other

Are your animals: ☐ indoors ☐ outdoors ☐ both

Are you exposed to any of the following at home or work?

☐ mold ☐ cockroaches ☐ humidifier ☐ hot tub
☐ fumes ☐ farm animals ☐ dust ☐ grain silos

Have you been exposed to asbestos? ☐ No ☐ Yes

Constitutional

Recent weight loss	☐ No	☐ Yes
Recent night sweats	☐ No	☐ Yes
Recent fevers	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes

Eyes

Vision loss	☐ No	☐ Yes
Other eye diseases	☐ No	☐ Yes

Ears / Nose / Throat

Hearing loss	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes
Dental disease	☐ No	☐ Yes
Post nasal drip	☐ No	☐ Yes
Nasal congestion	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes

Neurological

Headaches	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Strokes	☐ No	☐ Yes

Skin

Recent skin rash	☐ No	☐ Yes
Skin cancer	☐ No	☐ Yes

Cardiac

Chest pain	☐ No	☐ Yes
Passing out spells	☐ No	☐ Yes
Heart murmurs	☐ No	☐ Yes
Palpitations or feeling the heart race	☐ No	☐ Yes

Hematologic

Easy bruising / bleeding	☐ No	☐ Yes
Anemia	☐ No	☐ Yes

Gastrointestinal

Difficulty swallowing	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Blood in the stool	☐ No	☐ Yes
Stomach pain	☐ No	☐ Yes

Genitourinary

Miscarriages	☐ No	☐ Yes
Impotence	☐ No	☐ Yes
Blood in the urine	☐ No	☐ Yes
Difficulty urinating	☐ No	☐ Yes

Rheumatologic

Arthritis or joint aches	☐ No	☐ Yes
Muscle aches	☐ No	☐ Yes
Weakness	☐ No	☐ Yes
Swelling of the ankles	☐ No	☐ Yes

Allergy

Seasonal hay fever	☐ No	☐ Yes
Animal allergies	☐ No	☐ Yes

Constitutional

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Panic attacks	☐ No	☐ Yes

Do you snore more than 2 times per week or is your snoring extremely loud?	☐ No	☐ Yes
Has anyone ever told you or noticed that you stop breathing when you sleep?	☐ No	☐ Yes
Do you have excessive sleepiness or fall asleep easily during the day	☐ No	☐ Yes
Do you get uncomfortable, crawling, or strange sensation in your legs that is relieved by moving or walking?	☐ No	☐ Yes
Have you had episodes where you screamed out in the middle of the night but did not remember it the next day?	☐ No	☐ Yes
Do you regularly or frequently wake up during the night?	☐ No	☐ Yes
Is difficulty falling asleep a recurring or bothersome problem for you?	☐ No	☐ Yes
Do you frequently have headaches in the morning?	☐ No	☐ Yes
Have you ever been told that you struck someone, became violent, or threatening while you slept?	☐ No	☐ Yes
Have you or do you lose muscle control or go limp when you are surprised, are laughing or get angry?	☐ No	☐ Yes