Not filling out paperwork completely may delay appointment time.

THE IOWA CLINIC PULMONARY AND SLEEP MEDICINE NEW PATIENT INFORMATION

NAME_____ Age____ Gender____Birthdate _____ Exam Date _____

REVIEW OF SYSTEMS -Check Yes (for current symptoms) or No

Headaches	Yes ☐	No ☐	Joint Pain/Stiffness	Yes ☐	No ☐
Seizures/Blackouts	Yes ☐	No ☐	Bone Problems	Yes ☐	No ☐
Visual Disturbance	Yes ☐	No ☐	Numbness in Arms	Yes ☐	No ☐
Hearing loss/Ringing in ears	Yes ☐	No ☐	Skin Rash/Infection	Yes ☐	No ☐
Dizziness/Vertigo	Yes ☐	No ☐	Abnormal Bleeding	Yes ☐	No ☐
Swallowing Problems	Yes ☐	No ☐	Easy Bruising	Yes ☐	No ☐
Heartburn	Yes ☐	No ☐	Loss of Consciousness	Yes ☐	No ☐
Abdominal Pain	Yes ☐	No ☐	Chest Pain	Yes ☐	No ☐
Bowel Disturbance	Yes ☐	No ☐	Heart Fluttering	Yes ☐	No ☐
Liver Disease/Jaundice	Yes ☐	No ☐	Swelling of Ankles	Yes ☐	No ☐
Blood in Stools	Yes ☐	No ☐	Short of Breath	Yes ☐	No ☐
Hemorrhoids	Yes ☐	No ☐	Wheezing	Yes ☐	No ☐
Nausea/Vomiting	Yes ☐	No ☐	Cough/Sputum Production/Blood	Yes ☐	No ☐
Bladder Problems	Yes ☐	No ☐	Sinus Trouble/Hay Fever	Yes ☐	No ☐
Kidney Stones	Yes ☐	No ☐	Fevers/Chills	Yes ☐	No ☐
Weight Loss	Yes ☐	No ☐	Night Sweats	Yes ☐	No ☐
Weight Gain	Yes ☐	No ☐	Snoring	Yes ☐	No ☐
Appetite Change	Yes ☐	No ☐	Sleepiness During the Day	Yes ☐	No ☐
Depression	Yes ☐	No ☐	Short of Breath at Night	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Drowsy While Driving	Yes ☐	No ☐
			Restless	Yes ☐	No ☐

Allergies to Medications (List)

_____ _____

_____ _____

_____ _____

Time to Bed _____

Time out of Bed _____

Medications - Current

Name	Dose & Frequency	Name	Dose & Frequency
1._____	_____	7._____	_____
2._____	_____	8._____	_____
3._____	_____	9._____	_____
4._____	_____	10._____	_____
5._____	_____	11._____	_____
6._____	_____	12._____	_____

Pharmacy Name_____ **Address**_____

Vaccinations:

Pneumovax and year_____ **Flu and year**_____ **Tetanus and year**_____ **Other**_____

FAMILY HISTORY

	If Living/age	If deceased/age	List any Medical Illness and Cause of death
Father			
Mother			
Brothers			
Sisters			
Children			

Check if Blood Relatives with

	maternal	/	paternal
☐ Heart Disease	☐		☐
☐ Asthma	☐		☐
☐ Diabetes	☐		☐
☐ Hypertension	☐		☐
☐ Lung Disease	☐		☐
☐ Tuberculosis	☐		☐
☐ Allergies	☐		☐
☐ Cystic Fibrosis	☐		☐
☐ Sleep Apnea	☐		☐
☐ Lung Cancer	☐		☐
☐ Cancer / Type	☐		☐

SOCIAL HISTORY

Habits

Tobacco Yes ☐ No ☐ If yes, how much?_____ **ppd**_____How long?_____

If former smoker: When did you quit?_____ **How long did you smoke?**_____

Alcohol Yes ☐ No ☐ If yes, **how much?**_____ How long?_____

Marital Status_____ Occupation_____ If retired, previous occupation_____

Recent Travel Outside US or SW_____

Hobbies_____

Office use only:
I have reviewed the above history and have made appropriate additions and/or corrections. See dictation.

*Physician Signature*_____ *Date*_____

Medical Illnesses (check Yes/No)			**If Yes, Date of Onset**
Diabetes	Yes ☐	No ☐	
Heart Disease	Yes ☐	No ☐	
High Blood Pressure	Yes ☐	No ☐	
Stroke	Yes ☐	No ☐	
Lung Disease	Yes ☐	No ☐	
Cancer / Type	Yes ☐	No ☐	
Thyroid Disease	Yes ☐	No ☐	
Sleep Apnea	Yes ☐	No ☐	
Pulmonary Embolism	Yes ☐	No ☐	
Tuberculosis	Yes ☐	No ☐	Treatment Yes ☐ No ☐

Please List Other / Past Medical History Medical Illnesses / Hospitalizations

1._____
2._____
3._____
4._____
5._____

PREVIOUS SURGERIES

Procedure	Date	Procedure	Date
1._____		5._____	
2._____		6._____	
3._____		7._____	
4._____		8._____	