# SCHENECTADY PULMONARY & CRITICAL CARE ASSOCIATES
## Patient Data Sheet

DATE

In order for us to provide you with safe and effective health care, this form must be completed thoroughly.
*If you need help completing this form, please ask for assistance!*

NAME | DATE OF BIRTH

PHARMACY NAME, ADDRESS, AND PHONE

PRIMARY MEDICAL DOCTOR | WHY WERE YOU REFERRED TO OUR PRACTICE?

**Race (circle one):** Caucasian African American Asian Native American Other: _____ Declined **Ethnicity (circle one):** Hispanic Non-Hispanic Declined

**Primary Language (circle one):** English French Spanish Other_____

LIST YOUR OTHER DOCTORS, AND WHY YOU SEE THEM *Example: Dr. Jane Smith – Heart Disease*

**MEDICAL PROBLEMS (Circle all that apply)**

Anemia Arrhythmia Arthritis (Osteo or Rheumatoid) Asthma Cancer Chronic Pain
Cirrhosis COPD (Emphysema or Chronic Bronchitis) Coronary Artery Disease
Cystic Fibrosis Diabetes Diverticulitis Diverticulosis DVT (Blood Clot in Leg or Arm)
Headache Heart Failure High Cholesterol Hypertension (High Blood Pressure) HIV/AIDS
Kidney Disease Liver Disease Lupus Osteoporosis Prostate Disease
Pulmonary Embolism (Blood Clot in Lung) Pulmonary Hypertension Reflux (GERD)
Sarcoidosis Seizure Sinusitis Sleep Apnea Stroke Thyroid Disease Transplant
Trauma/Deformity Tuberculosis Ulcerative Colitis or Crohn's Disease
***List Other Problems Below***

*List other problems on reverse

**MEDICATIONS** *Example: Toprol 50 mg 2x / day.*
Include inhaled meds, oxygen, & over-the-counter meds

*List Other meds on reverse

**HOSPITALIZATIONS and SURGERIES** (LIST ALL DETAILS, INCLUDING DATES – *Continue on reverse if necessary)

*PROBLEMS WITH ANESTHESIA?* ☐YES ☐NO (Discuss details with the Doctor)

**FAMILY HISTORY** List major medical problems; if a family member has died, list age and cause of death

MOTHER

FATHER

SIBLINGS

CHILDREN

OTHER BLOOD RELATIVES

**WORK HISTORY**: List all jobs and the type of work you performed *Example: GE - Foundry Worker*

**MARITAL STATUS**: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

**DO YOU SMOKE**, or did you ever smoke regularly? ☐YES ☐NO *If yes, discuss in detail with the doctor today! Also, please be prepared to discuss alcohol and drug use and second-hand smoke exposure with the doctor today!*

**PETS** in home:

**RECENT TRAVEL** outside of state

**HAVE YOU BEEN HEAVILY EXPOSED TO or USED**: ☐Asbestos ☐Diet Pills ☐Heavy Metals ☐Hormone Replacement ☐Silica?

**YEAR** ('x' = never) of Last **Flu Shot** _____ **Pneumonia Vaccine** _____ **Tuberculosis Skin Test** _____ (☐Check if POSITIVE)



***NOT DONE YET! Please turn over***

## PATIENT NAME:

**REVIEW OF SYSTEMS** Rate Your General Health Recently ☐Excellent ☐Good ☐Fair ☐Poor

***For each section, please check each of the problems you have had recently, or have had chronically***

*GENERAL*
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

*EYES*
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Other Eye Surgery (e.g., Lasik)
- ☐ Wear Corrective Lenses

*ENMT*
- ☐ Bad Taste in Mouth
- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Earaches
- ☐ Ear Drainage
- ☐ Hearing Loss
- ☐ Hoarse Voice/Voice Change
- ☐ Mouth Sores
- ☐ Nasal Polyps
- ☐ Nosebleeds
- ☐ Painful Swallowing
- ☐ Post Nasal Drip
- ☐ Runny Nose
- ☐ Swollen Glands in Neck

*CARDIOVASCULAR*
- ☐ Angina/Chest Pain
- ☐ Ankle/Leg/Hand Swelling
- ☐ Calf Pain When Walking
- ☐ Cold Extremities
- ☐ Heart Murmur
- ☐ Lightheadedness
- ☐ Palpitations
- ☐ Shortness of Breath Lying Flat
- ☐ Waking Up Short of Breath

*RESPIRATORY*
- ☐ Coughing Up Blood
- ☐ Coughing Up Sputum
- ☐ Cough When Eating
- ☐ Dry Cough
- ☐ Pain with Deep Breathing/Cough
- ☐ Shortness of Breath on Exertion
- ☐ Wheezing

*GASTROINTESTINAL*
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Constipation
- ☐ Dark/Black or Bloody Stool
- ☐ Diarrhea
- ☐ Increase in Abdominal Girth
- ☐ Loss of Appetite
- ☐ Painful Bowel Movements
- ☐ Vomiting or Retching
- ☐ Vomiting Blood

*GU: General*
- ☐ Blood In Urine
- ☐ Burning or Pain with Urination
- ☐ Incontinence / Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Sexually Transmitted Disease

*GU: Female*
- ☐ Hot Flashes
- ☐ Irregular Periods

Last Pap Smear _____
# of Pregnancies _____
# of Abortions/Miscarriages _____

- ☐ Painful Periods
- ☐ Post-Menopausal
- ☐ Vaginal Discharge

*GU: Male*
- ☐ Difficulty Starting Urine Flow
- ☐ Testicular Pain

*MUSCULOSKELETAL*
- ☐ Back Pain
- ☐ Difficulty Walking
- ☐ Joint Injury
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling or Redness
- ☐ Muscle Aches
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Sciatica

*INTEGUMENTARY*
- ☐ Breast Lump
- ☐ Breast Pain or Swelling
- ☐ Change in Hair
- ☐ Change in Nails
- ☐ Change in Skin Color
- ☐ Eczema

Female: Last Mammogram _____

- ☐ Itching
- ☐ Rash
- ☐ Skin Cancer

*NEURO*
- ☐ Balance Problems
- ☐ Dementia (e.g., Alzheimer's)
- ☐ Dizziness
- ☐ Headache (Migraine or Other)
- ☐ Head Injury
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizure / Epilepsy
- ☐ Tingling/Burning (Neuropathy)
- ☐ Tremor/Tic

*PSYCH*
- ☐ Anxiety
- ☐ Confusion
- ☐ Depression
- ☐ Memory Loss
- ☐ Severe Stress or Recent Loss
- ☐ Suicidal Thoughts / Attempts

*ENDOCRINE*
- ☐ Change in Hat/Glove Size
- ☐ Cold Intolerance
- ☐ Dry Skin
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Goiter
- ☐ Heat Intolerance
- ☐ Other Endocrine Disease

*HEMATOLOGIC*
- ☐ Anemia
- ☐ Bleeding or Bruising Tendency
- ☐ Phlebitis
- ☐ Poor Wound Healing
- ☐ Swollen Glands
- ☐ Transfusion

*ALLERGY*
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other Antibiotics (Specify):

- ☐ Aspirin
- ☐ IV Contrast
- ☐ Morphine or Demerol
- ☐ Tetanus
- ☐ Environmental (Specify):

- ☐ Foods (Specify):

- ☐ Other (Specify):

*SLEEP*
- ☐ Excessive Daytime Sleepiness
- ☐ Morning Headache
- ☐ Poor Sleep Quality
- ☐ Snoring

*Use this space to complete information from other side, or for additional medical information

Do Not Write Below This Line – DOCTOR'S NOTES