PULMONARY ALLERGY CRITICAL CARE & SLEEP ASSOCIATES

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PATIENT ASSESSMENT PROFILE

Patient Name: _____ Age: _____ Sex: ☐ M ☐ F Date: _____

Referred By: _____ Pharmacy Name/Phone: _____

Chief Complaint: _____

History of Present Illness: _____

Past Medical History (*check all that apply*):

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Cancer
  Type: _____
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Sinus Trouble
- ☐ Thyroid Problem
- ☐ Kidney Problem
- ☐ Diabetes Mellitus
- ☐ Arthritis
- ☐ Seizures
- ☐ Venereal disease
- ☐ Drug Abuse
- ☐ Tuberculosis

Previous Surgeries: _____

Smoking: ☐ Y ☐ N Packs/Day? _____ How Long? _____ Quit? _____ If yes, when? _____

Drinking: ☐ Y ☐ N How Much? _____ How Long? _____ Quit? _____ If yes, when? _____

Occupation/Employment: _____

Industrial Exposure: _____

Household Pets: _____

Review of Symptoms (*check all that apply*):

- ☐ Chest Pain
- ☐ Cough
- ☐ Sputum/Phlegm
- ☐ Cough Blood
- ☐ Short of Breath
- ☐ Fever
- ☐ Night Sweats
- ☐ Nasal Congestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Bloody Nose
- ☐ Weight Loss
- ☐ Headache
- ☐ Dizziness

Family History:

	State of Health
Mother	
Father	
Brother	
Sister	

Patient Allergy History:

Allergy	Type of Reaction	When

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