

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):

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Tuberculosis |
- Type: _____

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):

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Sputum/Phlegm | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Cough Blood | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Bloody Nose |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Dizziness |

Family History:

State of Health
Mother _____
Father _____
Brother _____
Sister _____

Patient Allergy History:

Allergy	Type of Reaction	When
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____