



**Drs. Albert, Lindner, Cohen, Mendello, Bookman, Martin & Roy**

**PULMONARY / CRITICAL CARE / SLEEP MEDICINE**

**CONSULT FORM**

**PATIENT'S NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**DOB** \_\_\_\_\_ **AGE** \_\_\_\_\_ **CHART #** \_\_\_\_\_  
**REQUESTING PHYSICIAN** \_\_\_\_\_ **TELEPHONE #** \_\_\_\_\_  
**ADDRESS OF REQUESTING PHYSICIAN** \_\_\_\_\_  
**PERSON TO CONTACT IN CASE OF AN EMERGENCY OTHER THAN SPOUSE:**  
\_\_\_\_\_ **TELEPHONE #** \_\_\_\_\_

**PATIENT HISTORY**

**REASON FOR THIS DR. VISIT:** \_\_\_\_\_  
\_\_\_\_\_

**RESPIRATORY HISTORY:**

**Cough** for \_\_\_ Mo /Yrs.  **Sputum** for \_\_\_ Mo /Yrs.  
 Mild  Moderate  Severe  Tsp  Shot glass  1/2-1 Cup  >Cup  
 Chronic Bronchitis  Clear/White  Yellow/Green  Blood

Aggravating Factors:

Relieving Factors:

**Dyspnea** for \_\_\_ Wk /Mo /Yrs.  **Wheezing** for \_\_\_ Wk /Mo /Yrs.  
 Rest  Few Feet  Around House  
\_\_\_ Blocks \_\_\_ Miles \_\_\_ Stairs

Post exercise duration \_\_\_ Sec/Min

Aggravating Factors:

Relieving Factors:

**Sleepiness** for \_\_\_ Wk /Mo /Yrs.  **Chest Pain** for \_\_\_ Mo /Yrs.  
 Snore  Kicking  Characteristics:  
ESS \_\_\_  Vivid Dreams  Aggravating Factors:  
 Apnea  Weakness  Relieving Factors:  
 AM HA  Sleep Paralysis

Aggravating Factors:

Relieving Factors:

Bed /Awake /Arousal +/- urination

**SURGERY DATES:**

**ILLNESS DATES:**

_____ Pneumonia	_____ Heart Attack	_____ Diabetes	_____ Liver Disease
_____ Emphysema	_____ Heart Palpitations	_____ Thyroid Disease	_____ Kidney Stones
_____ Bronchitis	_____ Heart Murmur	_____ Cancer	_____ Epilepsy/Seizure
_____ Asthma	_____ Heart Failure	_____ Osteoporosis	_____ Depression
_____ Pleurisy	_____ High Blood Pressure	_____ Arthritis	_____ Anxiety
_____ Tuberculosis	_____ Blood Clot in Lung	_____ Anemia /Transfusion	_____ Stroke
_____ Hay Fever / Allergies	_____ Clotting in Legs	_____ Ulcers	_____ Other
_____ Sinus Infections	_____ Peripheral Vasc. Dz.	_____ Colitis	

**MEDICATIONS:**

1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

Currently on O<sub>2</sub>: [ ] Yes \_\_\_ L/m Rest \_\_\_\_\_ [ ] No  
Exercise \_\_\_\_\_  
Sleep \_\_\_\_\_

**DRUG ALLERGIES:**

Medication	Type of Reaction	Medication	Type of Reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

[ ] Aspirin [ ] Latex [ ] Foods

**VACCINATIONS:** Year of last vaccination: \_\_\_\_\_ **INFLUENZA** \_\_\_\_\_ **PNEUMONIA**

**TEST DATES:**

\_\_\_\_\_ Colonoscopy    \_\_\_\_\_ Mammogram    \_\_\_\_\_ Bone Densiometry    \_\_\_\_\_ Prostate

**TOBACCO HISTORY:** Have you ever used tobacco? [ ] Yes [ ] No

[ ] Cigarettes [ ] Cigars [ ] Pipe [ ] Smokeless tobacco (snuff)

Age started smoking? \_\_\_\_\_ yrs.

On average, how many packets per day do you smoke? \_\_\_\_\_ packs

Are you still smoking? [ ] Yes [ ] No

If not, when did you quit? \_\_\_\_\_ yrs. ago

**ALCOHOL:** [ ] Socially [ ] To excess on occasion [ ] Daily [ ] Previous / current alcohol addiction

[ ] Beer [ ] Liquor [ ] Wine

**DRUGS:** \_\_\_\_\_

**OCCUPATIONS /HOBBIES:** Please list all your occupations beginning with your current job.

1. \_\_\_\_\_

4. \_\_\_\_\_

2. \_\_\_\_\_

5. \_\_\_\_\_

3. \_\_\_\_\_

6. \_\_\_\_\_

**Asbestosis exposure?** [ ] Yes [ ] No

**Other exposure?** \_\_\_\_\_

**RECENT TRAVEL: PLACE & DATE(S)** \_\_\_\_\_

**PETS:** \_\_\_\_\_

**SOCIAL HISTORY:** [ ] Single [ ] Married [ ] Widow(er) [ ] Divorced

**EDUCATION:** [ ] Grade school [ ] High School [ ] College

**FAMILY HISTORY:** If living, give age and health. If deceased, give age at death and cause of death.

Maternal Grandmother: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Maternal Grandfather: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Paternal Grandmother: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Paternal Grandfather: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Mother: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Father: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Sister: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Brother: Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Children: Sex \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_ Cause \_\_\_\_\_

**Have any of your BLOOD relatives ever had:**

\_\_\_\_\_ Asthma      \_\_\_\_\_ Tuberculosis      \_\_\_\_\_ Cancer      \_\_\_\_\_ Cystic Fibrosis  
\_\_\_\_\_ Emphysema      \_\_\_\_\_ High Blood Pressure      \_\_\_\_\_ Diabetes      \_\_\_\_\_ Other  
\_\_\_\_\_ Bronchitis      \_\_\_\_\_ Stroke      \_\_\_\_\_ Epilepsy

**PERSONAL HISTORY:**

**GENERAL:**

\_\_\_\_\_ Weight [ ]Gain [ ]Loss  
\_\_\_\_\_ lbs.  
\_\_\_\_\_ Fever  
\_\_\_\_\_ Chills / Night Sweats  
\_\_\_\_\_ Abnormal sleep  
[ ]Snoring [ ]Apnea [ ]Insomnia

**HEART AND VASCULAR:**

\_\_\_\_\_ Claudication  
\_\_\_\_\_ Heart murmur  
\_\_\_\_\_ Rapid, irregular, or pounding heart beat  
\_\_\_\_\_ Swelling in legs or ankles  
\_\_\_\_\_ Waking up at night short of breath  
\_\_\_\_\_ Need to sleep on more than one pillow

**GENITOURINARY:**

\_\_\_\_\_ Painful urination  
\_\_\_\_\_ Blood in urine  
\_\_\_\_\_ Frequent urination  
\_\_\_\_\_ Nocturia  
\_\_\_\_\_ Discharge (penile / vaginal)  
\_\_\_\_\_ Difficulty starting or emptying  
bladder / Incontinence

**EYES:**

\_\_\_\_\_ Decreased /Blurred vision  
\_\_\_\_\_ Glasses or contacts  
\_\_\_\_\_ Pain in eyes  
\_\_\_\_\_ Dry eyes  
[ ]Cataracts [ ]Glaucoma

**GASTROINTESTINAL:**

\_\_\_\_\_ Frequent heartburn  
\_\_\_\_\_ Frequent reflux  
\_\_\_\_\_ Nausea / vomiting  
\_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Constipation / change in bowel habits  
\_\_\_\_\_ Abdominal pain  
\_\_\_\_\_ Blood in stool  
\_\_\_\_\_ Difficulty swallowing / aspiration

**FOR WOMEN ONLY:**

\_\_\_\_\_ Irregular periods  
\_\_\_\_\_ Bleeding between periods  
\_\_\_\_\_ Date of last period

**EAR, NOSE, & THROAT:**

\_\_\_\_\_ Earaches  
\_\_\_\_\_ Ringing in ears  
\_\_\_\_\_ Loss of hearing  
\_\_\_\_\_ Sinus problems  
\_\_\_\_\_ Nose congested or runny  
\_\_\_\_\_ Postnasal drainage  
\_\_\_\_\_ Frequent throat clearing  
\_\_\_\_\_ Epistaxis (bloody nose)  
\_\_\_\_\_ Persistent hoarseness / voice change  
\_\_\_\_\_ Dental problems

**MUSKULOSKELETAL:**

\_\_\_\_\_ Painful joints  
\_\_\_\_\_ Swollen or red joints  
\_\_\_\_\_ Back pain  
\_\_\_\_\_ Sore muscles

**NEUROPSYCHIATRIC:**

\_\_\_\_\_ Frequent or severe headaches  
\_\_\_\_\_ Dizziness  
\_\_\_\_\_ Loss of feeling in hands or feet  
\_\_\_\_\_ Passing out / fainting  
\_\_\_\_\_ Numbness / tingling in hands or feet  
\_\_\_\_\_ Tremors

**SKIN & BREASTS:**

\_\_\_\_\_ Rash  
\_\_\_\_\_ Enlarging / changing mole  
or lesion  
\_\_\_\_\_ Lump in breast  
\_\_\_\_\_ Nipple discharge  
\_\_\_\_\_ Raynaud's phenomenon  
\_\_\_\_\_ Telangiectasia  
\_\_\_\_\_ Alopecia

**HEMATOLOGIC / LYMPHATIC:**

\_\_\_\_\_ Easy bruising  
\_\_\_\_\_ Abnormal bleeding  
\_\_\_\_\_ Swollen lymph glands

**PSYCHIATRIC:**

\_\_\_\_\_ Depression  
\_\_\_\_\_ Anxiety / nervousness

**ENDOCRINE:**

\_\_\_\_\_ Steroid tablets or injections  
within the last year?  
\_\_\_\_\_ Hair loss  
\_\_\_\_\_ Hot / cold intolerance

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**VITALS EXAM: T PULSE RESP BP**

**WT** \_\_\_\_\_

(Regular / Irregular)

O<sub>2</sub> Sat. \_\_\_\_\_ on \_\_\_\_\_ L/m Neck

Size \_\_\_\_\_

<b>GENERAL:</b>	<input type="checkbox"/> Well appearing <input type="checkbox"/> Acutely ill <input type="checkbox"/> Chronically ill	<input type="checkbox"/> Well nourished <input type="checkbox"/> Malnourished <input type="checkbox"/> Obese	<b>Cardiovascular:</b>	<input type="checkbox"/> PMI <input type="checkbox"/> RRR NSR <input type="checkbox"/> Irregular <input type="checkbox"/> NI S1 S2 P2 <input type="checkbox"/> No ped. edema	<input type="checkbox"/> Brady / tachy <input type="checkbox"/> Extrasystole(Occ/freq ) <input type="checkbox"/> Grade ___/6 murmur <input type="checkbox"/> Gallop (S3, S4)
<b>EYES:</b>	<input type="checkbox"/> PERRLA <input type="checkbox"/> EOMI	<input type="checkbox"/> Fundi <input type="checkbox"/> Conj			
<b>ENMT:</b>	<input type="checkbox"/> NI nasal mucoses <input type="checkbox"/> Sinus <input type="checkbox"/> Polyps	<input type="checkbox"/> Septum <input type="checkbox"/> Turbinates <input type="checkbox"/> Tm	<b>ABDOMEN:</b>	<input type="checkbox"/> nI BS <input type="checkbox"/> NT / ND <input type="checkbox"/> No HSM <input type="checkbox"/> Aorta (size & bruits)	<input type="checkbox"/> No masses <input type="checkbox"/> Rectal deferred <input type="checkbox"/> No hernias <input type="checkbox"/> Scars
<b>Orthopharynx:</b>	<input type="checkbox"/> Normal, MMM <input type="checkbox"/> No thrush <input type="checkbox"/> No erythema / exudate	<input type="checkbox"/> Teeth / gums <input type="checkbox"/> Tongue <input type="checkbox"/> Uvula	<b>EXTREMITIES:</b>	<input type="checkbox"/> No clubbing <input type="checkbox"/> No cyanosis	<input type="checkbox"/> No cords or homans <input type="checkbox"/> Pulses
<b>NECK:</b>	<input type="checkbox"/> No lymph nodes, mass	<input type="checkbox"/> Midline trachea <input type="checkbox"/> No hoarseness, strider	<b>NEURO:</b>	<input type="checkbox"/> CN 2-12 <input type="checkbox"/> A & O X3 <input type="checkbox"/> Memory <input type="checkbox"/> Normal gait	<input type="checkbox"/> Motor 5/5 <input type="checkbox"/> Sensory normal <input type="checkbox"/> Tremors
<b>THYROID:</b>	<input type="checkbox"/> No thyromegaly	<input type="checkbox"/> No nodules			
<b>JVD:</b>	<input type="checkbox"/> No JVD	<input type="checkbox"/> Abn waveform	<b>MS:</b>	<input type="checkbox"/> Normal strength & tone <input type="checkbox"/> ROM	<input type="checkbox"/> Atrophy <input type="checkbox"/> JT swelling / deformity
<b>CAROTIDS:</b>	<input type="checkbox"/> Upstroke	<input type="checkbox"/> No bruits			
<b>RESP INSPEC:</b>	<input type="checkbox"/> NI symmetric expansion <input type="checkbox"/> Scars	<input type="checkbox"/> Kyphosis/scoliosis <input type="checkbox"/> Hyperinflated	<b>GU:</b>	<input type="checkbox"/> Deferred	
<b>EFFORT:</b>	<input type="checkbox"/> NI <input type="checkbox"/> Acc muscle use	<input type="checkbox"/> Pursed lip <input type="checkbox"/> Intercostal retractions	<b>LYMPH NODES:</b>	<input type="checkbox"/> Cervical, axillary, inguinal	
<b>PERCUSSION:</b>	<input type="checkbox"/> NI	<input type="checkbox"/> Dullness <input type="checkbox"/> Hyperressonant	<b>SKIN:</b>	<input type="checkbox"/> No rashes, lesions, or <input type="checkbox"/> No petichiae	<input type="checkbox"/> ulcers <input type="checkbox"/> No nodules
<b>Auscultation:</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Distant <input type="checkbox"/> Air exchange <input type="checkbox"/> Wheezes	<input type="checkbox"/> Rales <input type="checkbox"/> Rhonchi <input type="checkbox"/> Rubs	<b>PSYCH:</b>	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	

**RADIOLOGY:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**LABS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**IMPRESSIONS /PLAN:** \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CC:** \_\_\_\_\_