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CAPA

Capitol Area Pulmonary Associates
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PULMONARY CONSULTATION -NEW PATIENT

- Patient Name: _____
- Patient DOB: _____
- Patient INSURANCE: _____

- Address: Street:_____ City:_____State:_____ Zip:_____
- Home Phone Number:_____ Cell Phone Number:_____
- Age: ____Sex: Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated
- Race: ☐ Caucasian (White) ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other:
- Occupation:
- Height:_____ Weight:_____
- Has there been any recent weight gain or loss? ☐Yes ☐ No If Yes, a gain of_____ lbs or a loss of:_____ lbs.
- Over how many months has this weight gain or loss occurred?
- Healthcare Professional who referred you to us (Doctor, Physician's Assistant or Nurse Practitioner, Other):
- **Your main complaint(s):** ☐cough ☐ dyspnea ☐ wheezing ☐ abnormal x-ray ☐ Hospital FU
  - Other (please comment):
- How long have you had this problem? About ☐ months ☐ years
- How has this problem affected your life?

Have you seen a lung doctor in the past? If yes, who? _____ when? _____

Have you had breathing tests in the past? If yes, when? where? _____Have you had a chest X-ray or CT scan of chest? If yes, when?_____ where?_____

PAST MEDICAL HISTORY

❑ COPD/Emphysema
❑ Pulmonary embolism (blood clots in lungs) ❑Pulmonary Hypertension
❑ Lung cancer
❑ Pleural effusion (Fluid around lungs)
❑ coronary artery disease
❑Sleep apnea
❑ Other cancer
❑ Hypothyroidism
❑ Osteoarthritis
❑Pneumothorax
❑ Asthma
❑ Pulmonary fibrosis
❑ High Blood pressure

❑ Other chronic medical conditions _____
❑ Hospitalization for respiratory problems _____

Initials_____ date_____

PAST SURGICAL HISTORY

❑ Lung surgery ❑ CABG (bypass surgery) ❑ Heart valve replacement

❑ Cholecystectomy (gallbladder removal) ❑ Pacemaker/ICD placement ❑ IVC filter placement

❑ Other surgeries _____

ALLERGIES ❑ NO KNOWN DRUG ALLERGIES

❑ Medications ❑ None ❑ Yes _____

❑ Food ❑ None ❑ Yes _____

FAMILY HISTORY

	What type:	Which family member	when
Any cancer			
COPD			
tuberculosis			
Blood clots			

SOCIAL HISTORY

SOCIAL HISTORY (please circle answer and fill in the blank where appropriate)

- What is your occupation? _____If retired when? _____
- Do you smoke? ☐ Yes ☐ No Packs per day? _____ how long? _____
- Have you smoked in the past? ☐ Yes ☐ No Packs per day? _____ how long? _____ If you quit, when?_____
- Do you drink beer, wine, or liquor? ☐ Yes ☐ No How much? _____ How long? _____
- Were you exposed to any chemicals, fumes, or asbestos? If yes, What?_____
- Military history?_____
- Exercise History?_____PETS:_____
- Do you snore? ☐ Yes ☐ No
- Does your sleep position affect your snoring? ☐ Yes ☐ No
- Have you awakened from choking or short of breath? ☐ Yes ☐ No
- Has anyone noticed that you stop breathing while asleep? ☐ Yes ☐ No
- Do you have morning headaches? ☐ Yes ☐ No
- Do you awaken more than twice to urinate during the night? ☐ Yes ☐ No
- Do you awaken refreshed in the morning ☐ Yes ☐ No
- Do you awaken with an acid or sour taste in your mouth ☐ Yes ☐ No
- Do you have difficulty sleeping on your back? ☐ Yes ☐ No

MEDICATIONS LIST (Please include all medications including inhalers)

Initials _____Date_____

Medication	Dose	# Times/Day	Medication	Dose	#Times/Day

REVIEW OF SYSTEMS

	Yes	No		Yes	No
Recent weight gain > 10 lbs			Joint pain		
Recent weight loss > 10 lbs			Joint swelling		
Fatigue			Muscle weakness		
Fever			Muscle pain		
Night sweats					
Ringing in ears			Dizziness		
Loss of hearing			Weakness		
Frequent sore throats			Numbness or tingling		
Hoarseness			Memory loss		
Sinusitis			Headaches		
Shortness of breath			Loss of appetite		
Chronic cough			Heat intolerance		
Hemoptysis (coughing up blood)			Cole intolerance		
Wheezing			Blood in stool		
Pleurisy			Polydipsia (excessive thirst)		
Chest pain			Heartburn		
Palpitations			Abdominal pain		

Signature,_____ Date_____