**SANTA BARBARA PULMONARY ASSOCIATES**

 Your doctor

Robert S Wright, M.D.

Richard A. Belkin, M.D.

Nayan Patel, MD

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other physicians involved in your care (require a copy of this visit):

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

Reason you are seeing the doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | **DOCTORS USE ONLY** |  |  |  |  |  |
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**Past Medical History**: (diagnosed illnesses)

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**Past Surgical History:** (procedures done)

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| Name of Medication | Dose | Frequency |
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**Current Medications:**

**\*Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.**

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| **DOCTORS USE ONLY** |
|  |
| **Constitutional:** |
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|  |
| **Head, Ears, Nose, Mouth and Throat:** |
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|  |
| **Neck:** |
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| **Lymph node exam:** |
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| **Skin:** |
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| **Respiratory:** |
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| **Cardiovascular:** |
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| **Gastrointestinal:** |
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| **Musculoskeletal:** |
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| **Extremities:** |
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| **Neuro/Psychiatric:** |
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| **PLAN**: |
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| **Allergies** | Yes | No | List Any |
| Flu Vaccin |  |  |  |
| Pneumonia Vaccine |  |  |  |
| Shingles Vaccine |  |  |  |

**Family History:**

Mother Living: \_\_\_\_ Deceased: \_\_\_\_\_

Cause of death or health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Father Living: \_\_\_\_ Deceased: \_\_\_\_

Cause of death or health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Brothers Living: \_\_\_\_ Deceased: \_\_\_\_

Cause of death or health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Sisters Living: \_\_\_\_ Deceased: \_\_\_\_

Cause of death or health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Social History:**

Birth place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children: \_\_\_\_\_\_\_

Have you ever smoked? \_\_\_\_\_\_\_\_\_\_\_

Years smoked: \_\_\_\_\_\_\_\_\_\_

Packs per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you quit smoking? \_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_

How many drinks per week? \_\_\_\_\_

Do you use any other substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational exposures: \_\_\_\_\_\_\_\_

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

Pets/animals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Travel history in past 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Immunization Status** | Yes | No | Date |
| Flu Vaccine |  |  |  |
| Pneumonia Vaccine |  |  |  |
| Shingles Vaccine |  |  |  |

**Review of Current Symptoms:**

*Please check all that apply*

**Constitutional:**

* Fevers
* Chills
* Weight loss/weight gain
* Night sweats

**Skin***:*

* Rashes
* Lesions
* Ulcers
* Jaundice/discoloration

**Eyes** (Ojos)*:*

* Dry eyes
* Double vision
* Visual loss

**Head, Ears, Nose, Mouth and Throat:**

* Headaches
* Dizziness
* Vertigo
* Sore throat
* Thrush
* Hoarseness of voice
* Nasal discharge
* Nasal polyps
* Nasal obstruction
* Nasal epitasis
* Sinus congestion

**Cardiovascular:**

* Palpitations
* Irregular heartbeats
* Chest pain
* Hypertension
* Heart attack or M.I.

**Neurologic:**

* Difficulty with ambulation
* Numbness
* Difficulty with speech
* New onset seizures

**Lymphatic:**

* Lymph node enlargement

**Respiratory**:

* Shortness of breath
* Asthma
* Emphysema
* Bronchitis
* Valley Fever
* Cough
* COPD
* Snoring
* Coughing of blood
* Pneumonia
* Wheezing
* TB
* Sputum Production

**Gastrointestinal:**

* Heartburn/GERD
* Nausea
* Vomiting
* Abdominal pain
* Hematemesis: blood in vomit
* Hematochezia: blood in stool

**Musculoskeletal**:

* Color changes to fingers/Raynauds
* Muscle pains
* Joint pains
* Leg swelling

**Genitourinary:**

* Hematuria/blood in urine
* Dysuria/painful urination
* Genital discharge

**Psychiatric:**

* Anxiety
* Depression