State in your own words the reason(s) for coming to a pulmonary physician?

Who is your primary care physician (PCP)?___________________________

Who referred you the pulmonary section at Virginia Mason (if not your PCP)?______________

Please provide an address and contact information for your referring physician(s) (if not a VM provider) if you would like us to communicate with them:

Address:	Phone:
	Fax:

Please check off any of the symptoms listed below that you have experienced in the last month or in association with the reason you have come for this appointment.

☐ weight loss	☐ weight gain	☐ fatigue	☐ loss of appetite
☐ headaches	☐ lightheadedness	☐ loss of consciousness	☐ itchy-watery eyes
☐ runny nose	☐ post-nasal drip	☐ sinus fullness	☐ nasal congestion, trouble with taste or smell
☐ cough	☐ shortness of breath	☐ wheezing	☐ sputum / phlegm
☐ coughing up blood	☐ chest discomfort or tightness	☐ shortness of breath when lying down	☐ swelling in feet or ankles
☐ diarrhea	☐ constipation	☐ narrow or dark/black stools	☐ abdominal pain
☐ jaundice	☐ heartburn indigestion trouble swallowing	☐ coughing after eating	☐ changes in urination
☐ blood in urine	☐ burning with urination	☐ pain in joints or bones	☐ muscle aches
☐ swelling in joints	☐ skin rash	☐ itching	☐ new or changing skin lesions
☐ depressed mood	☐ anxiety	☐ lack of interest	☐ weakness
☐ numbness	☐ shooting pains	☐ easy bruising bleeding problems	☐ clotting problems
☐ trouble sleeping	☐ snoring	☐ sleepiness while awake	

Do you have any history of cancer?

Cancer Type	Year Diagnosed	Treatment

Have you ever had blood clots in the veins or a pulmonary embolism? ☐ Yes ☐ No

Please list any surgeries you have had and the year you had them.

Surgery	Year of Surgery	Hospital

Please list any medicines to which you have an allergy and the reaction caused by that medicine.

Drug	Reaction	Drug	Reaction

Please list as many details as possible of the medicines that you are currently taking, including all inhalers. Please include herbal and over the counter therapies.

Drug Name	Dose	Times per day	Drug Name	Dose	Times per day

Have you ever used tobacco products? ☐ Yes ☐ No

If so, please estimate the average number of packs per day, the total number of years you smoked, and when you last smoked.____

If still using tobacco products, do you have any interest in quitting? ☐ Yes ☐No

How much alcohol do you consume in an average week?___________________________________

Have you ever used injection drugs? ☐ Yes ☐ No

Did you have the influenza vaccine last year? ☐ Yes ☐ No

Have you had the pneumonia vaccine? ☐ Yes ☐ No When?_______________

Have you ever been exposed to asbestos? ☐ Yes ☐ No

Do you have any pets, including birds? ☐ Yes ☐ No

Do you have any hobbies that might impact your lungs? ☐ Yes ☐ No

Do you have any other exposures to your lungs that concern you? ☐ Yes ☐ No

Have you been exposed to Tuberculosis? ☐ Yes ☐ No

Have you ever had a skin test for Tuberculosis? ☐ Yes ☐ No
If so, when was it last done and what was the result?____

Where were you born?____

Where have you lived in the past and currently? ____

Where have you traveled in the past 5 years?____

What kind of work do you do now and in the past? ____

Family History: Please indicate the health or cause of death of family members as best you can.

	Medical Problems	**Age**	**Cause of death if deceased**	**Type of cancer, if any**
Mother				
Father				
Siblings				
Siblings				
Siblings				
Siblings				
Siblings				
Children				
Children				
Children				
Children				
Children				

Thank you.

PATIENT NAME & ID #

VIRGINIA MASON MEDICAL CENTER
PULMONARY PRE-HISTORY FORM

MRD: OUTPT

VMMC FORM 901281 (12-03)
FTF (3-8-04)