Granger Medical Clinic

West Jordan, Utah

A Member of the Granger Medical Family

Pulmonary & Sleep
Dr. Sandeep Chowdhary
Cassie Port, FNP-C

ACCT #: _____

Patient History Pulmonary Form

Date: _____

Name:	DOB
Phone:	Gender: ❑ Male ❑ Female

Occupation:

Referring Physician:	Primary Physician:

Have you ever seen a Pulmonologist (Lung Doctor) before? ❑ Yes ❑ No

Reason for your visit:

❑ Cough ❑ Wheezing ❑ Shortness of Breath at Rest ❑ Shortness of Breath with Exercise ❑ Snoring
❑ Coughing Up Blood ❑ Aspiration (Food Down the Wrong Pipe) ❑ Hoarseness ❑ Asthma
❑ Difficulty Swallowing ❑ Painful Swallowing
❑ Other:_____

Social History:

Have you ever been a Cigarette Smoker? ❑ Yes ❑ No If yes, how many packs per day?_____
How long? _____
Have you ever quit? ❑Yes ❑ No If yes, when? _____
Do you use Recreational Drugs? ❑ Yes ❑ No
Do you use Alcohol? ❑Yes ❑ No If yes, how many drinks per week? _____
Has Alcohol or Drugs ever been a problem? ❑Yes ❑No
Do you exercise? ❑Yes ❑ No
Have you ever used any diet aids? (Phen-fen, Ephedra, Dexatrim) ❑Yes ❑No

***If you see a Granger doctor, we have access to your medications there is no need to write them down.**

(Please attach a list if needed).

Medication	Strength's	Dose

Please list any allergies to any drugs and reactions (Ex: Penicillin – Cause a rash)

Mediation	Reaction	Medications	Reaction

Have you had a Chest X-Ray? ❑ Yes ❑ No If Yes, when? _____

Have you ever been prescribed Inhalers or Breathing Medication? ❑ Yes ❑ No

If yes, when?_____ How long did you take it for?_____

Have you ever been hospitalized for any breathing problems? ❑ Yes ❑ No

If yes, when?_____

Have you ever been expose to Tuberculosis (TB)? ❑ Yes ❑ No If yes, when? _____

Have you ever had a TB skin test? ❑ Yes ❑ No If yes, when?_____

Have you ever Experiences: ❑ Fever ❑ Chills ❑ Night Sweats ❑ Weight Loss Fatigue ❑ Malaise

Do you have any pets? (Dogs, cats, birds) ❑ Yes ❑ No If yes, what kind?_____

Have you traveled in the past 2 years? ❑ Yes ❑ No If yes, where? _____

Do you have? *(Please check all that apply)* ❑ Humidifier ❑ Air Cleaner/Purifier ❑ Indoor Hot Tub

❑ Steam Sauna/Steam Shower ❑ Swamp Cooler ❑ Water Damage or Mold/Mildew in the Home

Have you ever been expose to chemical, dust, asbestos? ❑ Yes ❑ No If yes, when?_____

Medical History:

Past Medical History: Please check all that apply

❑ High Cholesterol ❑ High Blood Pressure ❑ Diabetes ❑ High Thyroid
❑ Low Thyroid Depression ❑ Anxiety ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑ Stroke
❑Atrial Fibrillation ❑ Pacemaker ❑ Congestive Heart Failure ❑ COPD Asthma ❑ Seasonal Allergies
❑ Seizure ❑ Tremor Passing Out / Fainting ❑ Headaches ❑ Paralysis ❑ Loss of Sensation
❑Other:_____

Past Surgeries: What Year(s):

❑Tonsillectomy _____ ❑ Mastectomy_____ ❑ Gallbladder removal_____ ❑ C-Section_____
❑ Hysterectomy_____ ❑ Vasectomy_____
❑ Cancer:_____ Other: _____
_____

Family History: (Mother, Father, Siblings)

❑Depression ❑Anxiety ❑Diabetes ❑Thyroid Disease ❑Anemia ❑Acid Reflux
❑ Asthma ❑ Heart Disease
❑ Cancer: Other:

Healthcare Maintenance:

When was your last Physical? _____ Last Flu Shot?_____Last Pneumonia Vaccine?_____
Cholesterol Screening? _____ Diabetes Screening? _____
Woman: Last PAP Smear? _____ Last Mammogram? _____

Any other medical concerns we should know about:

_____
_____
_____
_____
_____