Weill Cornell Medicine

NewYork-Presbyterian
Lower Manhattan Hospital

New Patient Pulmonary Form

Name: _____ Date: _____

DOB: _____ Age: _____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be release to any person except when you have authorized us to do so.

What medical concern brings you to our office? _____

_____

_____

Marital Status *(circle)* S M D W

Occupation: *(If retired, previous occupation)* _____

_____

If disabled, check here: ☐ Nature of disability: _____

Birthplace: _____ Do you exercise routinely?*(circle)* No Yes

If Yes, what exercise/how often? _____

Have you ever smoked? *(circle)* No Yes - Cigar Pipe Cigarettes

If Yes: Number of Cigarettes a day _____ number of year's _____

If you have never smoked skip this question: Do you still smoke now? *(circle)* No Yes

If No, when did you quit? _____

Have you completed an Advanced Directives or do you have a Living Will? *(circle)* No Yes

Caffeine: Do you drink caffeinated (circle) coffee, teas, or sodas regularly? *(circle)* No Yes

number a day _____

Tell us a little about your home environment. *(e.g. live alone, with family, single parent, house, appt, etc.)*

_____

_____

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which? _____

_____

_____

Please turn over and complete other side of page.

Medical Information

Allergies: Are you allergic to any drugs? No Yes Please list:

_____ _____ _____

_____ _____ _____

Medications *(List all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

_____ _____ _____

_____ _____ _____

Medical Illness or Conditions. (*List any chronic conditions which you have been diagnosed to have?)*

_____ _____ _____

_____ _____ _____

Have you ever had or been diagnosed to have: *(check all that apply)*

Cataracts	☐	Heart Disease	☐	Ulcers	☐	Anemia	☐	Depression	☐
Glaucoma	☐	Heart Murmur	☐	Digestive Disorder	☐	Bleeding Disorders	☐	Frequent Infection	☐
Asthma	☐	High Blood Pressure	☐	Hemorrhoids	☐	Bone or Joint Disease	☐	Syphilis	☐
Allergies	☐	Pneumonia	☐	Kidney Disease	☐	German Measles	☐	High Cholesterol	☐
Stroke	☐	TB/Lung Disease	☐	Kidney Stone(s)	☐	Rheumatic Fever	☐	Prostate Enlargement	☐
Seizures/Epilepsy	☐	Pleurisy	☐	Diabetes or Pre Diabetes	☐	Chicken Pox	☐	Thyroid Disease	☐
Heart Attack or Angina	☐	Jaundice or Liver Disease	☐						
Cancer(type)	☐								

Operations: (Please list any surgery and approximate year)

Surgery Year

_____ _____

_____ _____

Hospitalizations: (Other than operations)

Reason Hospital Year

_____ _____ _____

_____ _____ _____

Please turn over and complete other side of page.

Family Medical History					
Relative	Age	Health (list significant illness)	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brother					
Sister					
Spouse					
Children					

Has any blood relative ever had? *(check if yes and indicate relationship)*

☐	Alzheimer's	
☐	High Blood Pressure	
☐	Bleeding Disease	
☐	Depression/Suicide	
☐	Allergies	
☐	Tuberculosis	
☐	Heart Disease	
☐	Stroke	
☐	Alcoholism	
☐	Asthma	
☐	Diabetes	
☐	Heart Attack before age 55	
☐	Seizures	
☐	Mental Disorder	
☐	Cancer	

Immunizations *(check if yes and indicate year of last injection)*

☐ Influenza _____

☐ Tetanus _____

☐ Pneumonia _____

☐ Hepatitis A or B _____

☐ MMR _____

☐ Other _____

Transfusion: Have you ever had a blood or plasma transfusion *(circle)* No Yes

Weight: Your weight now? _____ One year ago? _____ Maximum? _____When? _____

Please turn over and complete other side of page.

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of your last menstrual cycle? _____

Review of Symptoms (Please Check All That Apply)

Constitutional				
☐ Weight change	☐ Fever	☐ Chills	☐ Night sweats	☐ Poor appetite
☐ Fatigue	☐ Insomnia/ Difficulty sleeping		☐ None	
Eyes				
☐ Pain	☐ Discharge	☐ Dryness	☐ Vision change	☐ None
Ears/Nose/Mouth/Throat				
☐ Hearing loss	☐ Tinnitus/Ringing in ears	☐ Ear pain	☐ Ear discharge	☐ Nosebleeds
☐ Runny nose	☐ Post Nasal Drip	☐ Nasal congestion	☐ Mouth lesions	☐ Sore throat
☐ Painful swallowing	☐ None			
Cardiovascular				
☐ Chest pain	☐ Palpitations	☐ Passing out	☐ Edema/Swelling	☐ Leg cramps
☐ Lightheadedness	☐ Calf pain while walking	☐ Waking at night gasping for air		
☐ Inability to lay flat due to shortness of breath		☐ Decreased exercise tolerance		☐ None
Respiratory				
☐ Loud snoring	☐ Cough	☐ Coughing up blood	☐ Wheezing	☐ Sputum
☐ Daytime drowsiness	☐ Shortness of breath	☐ Breathing stopped while sleeping		☐ None
Gastrointestinal				
☐ Reflux	☐ Nausea	☐ Vomiting	☐ Abdominal Pain	☐ Diarrhea
☐ Constipation	☐ Heartburn/Indigestion	☐ Vomiting Blood	☐ Dark, black stools	☐ Jaundice
☐ None				
Musculoskeletal				
☐ Joint Pain	☐ Muscle Pain	☐ Fractures	☐ Bone Pain	☐ None
Genitals/Urinary				
☐ Painful urination	☐ Urinary incontinence	☐ Urinating at night	☐ Increased Urinary frequency	
☐ Urinary urgency	☐ Blood in urine	☐ Penile discharge	☐ Erectile dysfunction	☐ Genital lesions
☐ Vaginal bleeding	☐ Vaginal discharge	☐ Cessation of menstrual periods		☐ None
Skin				
☐ Rash	☐ Skin ulcers	☐ Hair loss	☐ Skin changes	☐ None
Neurological				
☐ Weakness	☐ Headache	☐ Memory loss	☐ Convulsions	☐ Vertigo
☐ Tremors	☐ Numbness/Tingling	☐ None		
Endocrine				
☐ Heat intolerance	☐ Cold intolerance	☐ Excessive urination	☐ Excessive thirst	☐ None
Blood/Lymph Nodes				
☐ Easy Bleeding	☐ Easy Bruising	☐ Enlarged lymph nodes		☐ None
☐ Use of anticoagulants/blood thinners				

Please turn over and complete other side of page.

Allergies/Immune System

☐ Hives ☐ Cold/painful hands ☐ Skin tightness ☐ Swelling from allergies
☐ Morning stiffness ☐ Life-threatening allergic reactions ☐ None

Psychiatric

☐ Depressed mood ☐ Inability to feel happy ☐ Anxiety ☐ Suicidal thoughts ☐ Hallucinations
☐ Hearing voices ☐ None

Other

Please turn over and complete other side of page.