Weill Cornell Medicine

Pulmonary & Critical Care Medicine

Name: _____ **Date:** _____ **MRN:** _____
(TO BE COMPLETED BY FRONT DESK)

Review of Systems (Please Check All That Apply)

Constitutional

☐ Fever ☐ Chills ☐ Weight loss ☐ Night sweats ☐ Poor appetite
☐ Fatigue ☐ Difficulty sleeping

Sleep

☐ Snoring ☐ Gasping ☐ Insomnia ☐ Restless legs

Ears/Nose/Mouth/Throat

☐ Hearing loss ☐ Ringing ☐ Ear pain ☐ Runny nose ☐ Post nasal drip
☐ Nose bleeding ☐ Sores in mouth ☐ Sore throat ☐ Painful swallowing ☐ Blurry vision
☐ Change in vision ☐ Double vision ☐ Eye pain ☐ Change in sense of smell

Cardiovascular

☐ Chest pain ☐ Palpitations ☐ Swollen legs ☐ Leg pain in walking ☐ Leg cramps
☐ Dizziness ☐ Fainting ☐ Waking out of sleep because you can't breathe

Respiratory

☐ Shortness of breath ☐ Cough ☐ Coughing up blood ☐ Coughing up phlegm ☐ Wheezing

Gastrointestinal

☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Heartburn

Musculoskeletal

☐ Muscle pain ☐ Bone pain ☐ Joint pain ☐ Swollen/red joints ☐ Broken bones

Genitourinary

☐ Difficulty urinating ☐ Vaginal discharge ☐ Penile discharge ☐ Kidney stones

Skin

☐ Rash ☐ Ulcers that won't heal ☐ Changing moles

Endocrine

☐ Heat intolerance ☐ Cold intolerance ☐ Frequent urination ☐ Excessive thirst

Neurological

☐ Headache ☐ Weakness ☐ Seizure ☐ Dizziness ☐ Tremor
☐ Neuropathy

Blood/Lymph Nodes

☐ Easy bleeding ☐ Swollen lymph nodes

Psychiatric

☐ Depression ☐ Anxiety ☐ Hallucinations

Are you a:

☐ **Smoker** ☐ **Non-Smoker** ☐ **Ex-smoker**

Do you use any of the following?

☐ **Cigarettes** ☐ **Vaporizers** ☐ **E-cigarettes** ☐ **Shisha** ☐ **Cigars**

Weill Cornell Medicine

New Patient Form

Name: _____ **Date:** _____ **Referring or Primary Care Doctor:** _____

Check any frequent breathing problems you may have had during childhood:

Please list any medications that you are allergic to:

Please list any foods that you are allergic to:

Please list any environmental/seasonal allergies:

Have you ever had:

	Yes	No	Details
Asthma			
COPD			
Blood Clots in leg (DVT) or lung (PE)			
Cancer			
Heart disease			
Pneumonia (lung infection)			
Tuberculosis or an abnormal test for TB			
Surgery			
Other major medical problems			

Have you been exposed to any type of lung toxins at work?

☐ **Yes** ☐ **No**

Have you had significant exposure to other lung toxins (at home or during hobbies?)

☐ **Yes** ☐ **No**

Do you have pets?

☐ **Yes** ☐ **No**

Have you ever been vaccinated against pneumococcus or pneumonia?

☐ **Yes** ☐ **No**

Have you been vaccinated against the flu (influenza) during the past 6 months?

☐ **Yes** ☐ **No**

Have you had a CAT scan (CT scan) or x-ray of your lungs?

☐ **Yes** ☐ **No**

Have you ever used medicated inhalers?

☐ **Yes** ☐ **No**