MINNESOTA LUNG CENTER

Patient Name: _____

Demographic Information

Name: _____ Date of Birth: _____/_____/_____

Mailing Address:_____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Number: _____

Email Address: _____

Preferred method of contact (circle one): ☐ Phone ☐ Email ☐ Mail

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

Preferred Site (circle one): Mpls Edina Woodbury

MLC Physician

Do you see a Minnesota Lung Center Provider? ☐ Yes ☐ No Provider Name _____

Primary Care Provider

Name: _____ Practice: _____ Phone: _____(if known)

Secondary Provider (if applicable):

Name: _____ Practice: _____ Phone: _____(if known)

Pharmacy Information

Name: _____ Location: _____Phone:_____ (if known)

Medical Records Release

Can we obtain medical records to confirm medical history information gathered? ☐ Yes ☐ No

Patient Signature: _____ **Date**: _____

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Past Medical History **(check each condition that applies, include start date)**

Respiratory System:

- ☐ Asthma _____
- ☐ COPD _____
- ☐ Pulmonary Fibrosis_____
- ☐ Emphysema_____
- ☐ Chronic Bronchitis_____
- ☐ Tuberculosis or TB exposure _____
- ☐ Pneumonia_____
- ☐ Sarcoidosis_____
- ☐ Recurrent Sinusitis_____

Mental Health:

- ☐ Depression_____
- ☐ Anxiety_____
- ☐ Mental Illness_____

Endocrine:

- ☐ Diabetes_____
- ☐ Thyroid Disease_____

Musculoskeletal System:

- ☐ Osteoarthritis_____
- ☐ Osteoporosis_____
- ☐ Osteopenia_____
- ☐ Back Pain_____
- ☐ Degenerative Disc Disease___
- ☐ Arthritis_____

Nervous System:

- ☐ Restless Leg Syndrome _____
- ☐ Fibromyalgia_____
- ☐ Migraines_____
- ☐ Headaches_____
- ☐ Parkinsons_____
- ☐ Seizures_____

Cardiovascular System:

- ☐ High Cholesterol_____
- ☐ High Blood Pressure_____
- ☐ Heart Disease_____
- ☐ Atrial Fibrilation_____
- ☐ Angioplasty/Stents_____
- ☐ Heart Failure_____
- ☐ Stroke/TIA_____
- ☐ DVT/Blood Clot_____
- ☐ Pulmonary Emboli_____
- ☐ Abnormal Bleeding_____
- ☐ Chest Pain_____
- ☐ Irregular Heartbeat_____

Gastrointestinal System:

- ☐ GERD_____
- ☐ Peptic Ulcer_____
- ☐ Diverticulitis_____
- ☐ IBS_____
- ☐ Diarrhea_____
- ☐ Constipation_____

Immune/Lymphatic System:

- ☐ HIV/AIDS_____
- ☐ Hepatitis_____
- ☐ Lupus_____
- ☐ Rheumatoid Arthritis_____

Eyes, Ears, Nose, & Throat:

- ☐ Glaucoma_____
- ☐ Environmental /Seasonal Allergies _____
- ☐ Hearing Loss_____
- ☐ Cataracts_____
- ☐ Macular Degeneration_____

Urinary / Reproductive System:

- ☐ Kidney Stones_____
- ☐ BPH_____
- ☐ Overactive Bladder_____
- ☐ Urinary Incontinence_____
- ☐ Kidney Disease_____
- ☐ Surgically Sterile_____
- ☐ Hysterectomy_____

Other:

- ☐ Sleep Apnea_____
- ☐ Insomnia_____

Please List All Other Major and/or Minor Illnesses, include start dates:

_____
_____
_____

Please List All Surgeries and Dates:

_____
_____
_____
_____

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Breathing Flare-Ups (COPD Exacerbations)

Have you had any flare-ups of your breathing in the last 12 months that required an antibiotic, an oral steroid, and/or hospitalization to alleviate symptoms? Common symptoms include increased shortness of breath, increased cough, increased sputum production, increased wheezing, fever, and/or sore throat lasting for 2 or more days? ☐ **Yes** ☐ **No**

If yes, how many? _____

If yes, when did your last flare-up start? _____ **end?**_____

When was your last dose of antibiotic and/or oral steroid? _____

Cancer History

Have you had any type of cancer, including skin? ☐ **Yes** ☐ **No**

If yes, what type and when? _____

Substance History

Do you Currently Smoke ? ☐ **Yes** ☐ **No** **If Quit, When?** _____

How many years smoking? _____ **Average cigarettes per day during this time?** _____

Alcohol Consumption: _____ **# Drinks per** ☐ **Day** ☐ **Week** ☐ **Month** ☐ **Year**

Recreational Drugs? ☐ **Yes** ☐ **No Type:** _____

Allergies ☐ **No Known Allergies (Please check box if applies)**

Name of Allergen or Medication	Type of Reaction

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Medications **(Please list OR bring a copy of your own current list of medications)**

***Be sure to include all prescription medications, inhalers, nebulizer solutions, over-the-counter medications, vitamins, herbs and supplements**

Medication	Dosage	Times per Day	Start Date of Medication	Reason for Using Medication

(For office use)

Reviewed by CRC: _____ **Date:** _____

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