Dallas Diagnostic Association – Pulmonary & Critical Care

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Patient Name: _____ **D.O.B:** _____ **Date:** _____

Reason for visit? When did symptoms start: _____

Other concerns: _____ **I need medications refilled** _____

Do you smoke? Yes ☐ No ☐ If yes, how much? _____ When did you quit? _____

Are you experiencing any of the following problems? (check all that apply)

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats/diaphoresis
- ☐ Weakness

SKIN
- ☐ Rash
- ☐ Itching

HENT
- ☐ Headache
- ☐ Hearing loss
- ☐ Ringing ear/Tinnitus
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal congestion
- ☐ Stridor
- ☐ Sore throat

EYES
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitation
- ☐ Shortness of breath when lying down
- ☐ Leg pain with walking/claudication
- ☐ Leg swelling
- ☐ Gasping for air during sleep/PND

RESPIRATORY
- ☐ Cough
- ☐ Coughing up blood/hemoptysis
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Heart burn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark stool/Melena

GENITOURINARY
- ☐ Pain with urination/dysuria
- ☐ Urinary frequency
- ☐ Blood in urine/hematuria
- ☐ Flank pain

MUSCULOSKELETAL
- ☐ Muscle ache/myalgia
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Frequent Falls

ENDO/ALLERGY/HEMA
- ☐ Easy bruise/bleeding
- ☐ Environmental allergy
- ☐ Excessive thirst

NEUROLOGICAL
- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizure
- ☐ Loss of consciousness

PSYCHOLOGICAL
- ☐ Depression
- ☐ Suicide ideation
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous/anxious
- ☐ Insomnia
- ☐ Memory loss

Patient Signature: _____

Physician Signature: _____

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