UT Southwestern Medical Center
Aston Ambulatory Care Center
Patient Review of Systems
Pulmonary Diseases

Patient Name:
Date of Birth:
SSN#:
Date (mm/dd/yy):

PAST MEDICAL HISTORY:
(Diagnosis and date of onset)

_____
_____
_____
_____
_____

PAST SURGERIES:
(Name and date of surgery

_____
_____
_____
_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY:
(Check and provide relationship
i.e. mother, father, maternal uncle....)

Asthma	☐	_____
Emphysema	☐	_____
COPD	☐	_____
Hypertension	☐	_____
Diabetes	☐	_____
Cancer (type)	☐	_____
Auto Immune (Lupus, R.A.)	☐	_____
Heart Disease	☐	_____
Sarcoid	☐	_____
Other Respiratory	☐	_____
Other	☐	_____

ALLERGIES TO MEDICATIONS: _____
(describe type of reaction or side effect)

PULMONARY HEALTH MAINTENANCE:

Have you received the pneumonia vaccine (Pneumovax)? ☐ Date: _____

Have you received the influenza vaccine (flu shot)? ☐ Date: _____

SOCIAL HISTORY:
(Check box or fill out information)

Marital Status (S) (M) (D) (W)

Smoking History (No) (Yes)

Start (year): _____

Quit (year): _____

Average pack(s) per day: _____

Exercise: (describe activity per week) _____

_____

Drinking: (specify type of alcohol and ounces per day) _____

_____

ENVIRONMENTAL AND OCCUPATIONAL HISTORY:

Current occupation: _____

Prior type of employment: _____

Dust exposure: (None) (Yes) Start (year): _____

Quit (year): _____

Asbestos exposure: (None) (Yes) Duration of exposure: _____

Type of work: _____

Quit (year): _____

Mining: (None) (Yes) Start (year): _____

Sandblasting: (None) (Yes) Start (year): _____

Household birds: (None) (Yes) Describe: _____

Hot tub or sauna: (None) (Yes) Describe: _____

Household molds: (None) (Yes) Describe: _____

Other: (None) (Yes) Describe: _____

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REVIEW OF SYSTEMS

(Check the box next to the symptoms that you have noticed over the last year; leave blank if none apply)

___ Constitutional

No complaints ____

Poor appetite	____	Weight Loss	____	Fever	____	Chills	____
Night sweats	____	Weight gain	____	Fatigue	____	Snoring	____
Always tired	____	Malaise	____	Apnea	____	Choking	____
Restful sleep	____	AM Headaches	____	Blackouts	____		
Hot flashes	____	Sleepiness	____	Dizziness	____		

Other/Comments: _____

___ Eyes/Head

No complaints ____

Vision changes	____	Seeing spots	____	Itchy eyes	____
Double vision	____	Watery eyes	____	Headaches	____

Other/Comments: _____

____ Ear/Nose/Throat

No complaints ____

Hearing loss	____	Ringing ears	____	Ear pain	____
Nasal polyps	____	Nasal congestion	____	Nasal drainage	____
Change smell	____	Nose bleed	____	Sneezing	____
Sinus pain	____	Hoarseness	____	Bad breath	____
Sore throat	____	Change in taste	____		

Other/Comments: _____

____ Respiratory

No complaints ____

Cough	____	Pneumonia	____	Phlegm	____
Chest tightness	____	Chest injury	____	Pleurisy	____
Coughing blood	____	Wheezing	____		
Shortness of breath at rest	____			Exposure to tuberculosis	____
Shortness of breath with walking	____				

Other/Comments: _____

___ Heart

No complaints ____

Chest pain	____	Leg swelling	____	Heart skipping	____
Heart murmur	____	Passing out	____	Heart fluttering	____
Palpitations	____	Waking up short of breath	____		
Shortness of breath while laying flat	____				

Other/Comments: _____

___ Gastrointestinal

No complaints ____

Indigestion	____	Nausea	____	Vomiting	____
Bowel changes	____	Constipation	____	Belly pain	____
Bloody stools	____	Heartburn	____	Choking on food	____
Diarrhea	____	Pain swallowing	____		
Acid taste in mouth	____	Tar-colored stools	____		

Other/Comments: _____

___ Genitourinary

No complaints ____

Bloody urine	____	Frequent urination	____	Burning with urination	____
Inconsistence	____	Urination at night	____	Recent mammogram	____
Recent pap smear	____	Vaginal discharge	____	Abnormal periods	____
				Decrease in urine flow	____

Other/Comments: _____

___ Endocrine

No complaints ___
Excessive thirst ___ Frequent urination ___ Increased appetite ___
Heat intolerance ___ Cold intolerance ___

Other/Comments: _____

___ Musculoskeletal

No complaints ___
Arthritis ___ Muscle pain ___ Muscle weakness ___
Joint stiffness ___ Osteoporosis ___ Back pain ___

Other/Comments: _____

___ Skin/Breast

No complaints ___
Easy bruising ___ Nail changes ___ Warts ___ Acne ___
Hair loss ___ Hives ___ Moles ___ Itching ___
Discoloring ___ Boils ___ Rash ___ Lesions ___
Breast lump ___ Nipple discharge ___

Other/Comments: _____

___ Neurological

No complaints ___
Epilepsy ___ Seizures ("fits") ___ Paralysis ___
Tingling ___ Speech changes ___ Numbness ___
Headaches ___ Poor balance ___ Tremors ___
Memory problems ___ Lack of concentration ___

Other/Comments: _____

___ Psychiatric

No complaints ___
Anxious ___ Depressed ___ High stress ___
Mood swings ___ Hyperactive ___ Irritable ___
Hallucinations ___ Developmental delay ___

Other/Comments: _____

___ Heme/Lymph

No complaints ___
Anemia ___ Easy bruising ___ Swollen glands ___
Hemophilia ___ Easy bleeding ___ Sickle cell dz ___

Other/Comments: _____

___ Allergy/ Immunolgoy

No complaints ___
Nasal drainage ___ Crusting ___ Seasonal allergies ___
Allergy shots ___ Lupus ___ Frequent colds ___
Frequent infections ___ Autoimmune disease ___

Other/Comments: _____

Physician Review:

I have reviewed and discussed the Patient History and Review of Systems with the patient and/or patient's family.

Physician signature: _____ **Date:** _____