

Name: _____ Date of Evaluation ____/____/____/

Surgery:

Name of Surgery	Year	Surgeon	Hospital

If you need more room, check this box and add additional notes on page (5)

Hospitalizations for illness:

Year	Reason	Hospital

If you need more room, check this box and add additional notes on page (5)

Medications: Please list your current medications: *(include any Inhalers, Nebulizers and/or over- the- counter such as vitamins)*

Medication	Strength	Frequency

If you need more room, check this box and add additional notes on page (5)

Allergies to Medications:

Medication	Type of Reaction

If you need more room, check this box and add additional notes on page (5)

Family History:

Family Member	Living	Deceased	Age/Age at Death	Health Problems or Cause of Death
Father				
Mother				
Spouse				
Siblings				

If you need more room, check this box and add additional notes on page (5)

Check any disease that a blood relative may have had:

- Heart Disease
- High Blood Pressure
- Diabetes
- Cancer
- Asthma
- Tuberculosis
- Blood clotting disorders
- Thyroid Disease
- Kidney Disease
- Liver Disease
- Emphysema
- Strokes
- Other (please describe): _____
- Lupus
- Rheumatoid Arthritis
- Scleroderma
- Factor V Leiden Mutation
- Alpha-1 Antitrypsin Deficiency
- Cystic Fibrosis

Social History:

Marital Status: (Circle One)

Single / Married / Divorced / Widowed

Children:

Number of children: _____

Any Medical Problems? _____

Living Demographics:

Where did you grow up? _____

Where have you lived most of you life? _____

What is your level of education? _____

Exercise:

Do you exercise regularly? Y / N

History of Alcohol Use:

Do you consume alcohol? Y / N

If so, how many drinks per week? _____

Describe Your Home: (Circle one).

House / Apartment / Mobile Home / Other

Problems with water leaks, wet spots, black mold? Y / N

How is home heated? _____

Pets:

Do you have pets in your home? Y / N

Cat(s) / Dog(s) / Bird (s) / Farm Animals

History of Tobacco Use:

Do you smoke cigarettes/cigars? Y / N

If so, how many per day? _____

How many years have you smoked? _____

If you used to smoke, how long ago did you quit? _____

Do you live with a smoker? _____

Caffeine Use:

Do you consume caffeine? Y / N

If so, how many drinks per day? _____

Recreational Drug Use:

Do you use recreational drugs? Y / N

If yes, what type and how often? _____

Have you ever used I.V. drugs? Y / N

Employment History:

Are you working now? Y / N

Have you ever been exposed to asbestos, sand or dust at work? Y / N

Have you ever been exposed to radiation or strong fumes? Y / N

Shipyards work? Y / N

Electrician work? Y / N

Plumbing work? Y / N

What jobs have you done? _____

Occupational and Environmental Exposure History: (Please circle Y for Yes or N for No)

Have you ever worked in any of the following occupations or environments?

- | | | |
|----------------------------------|-------------------------|--|
| Y / N Pulp mill Worker | Y / N Mica Worker | Y / N Pipe Coverer |
| Y / N Saw mill Worker | Y / N Smelter | Y / N Mining |
| Y / N Cotton Mill Worker | Y / N Silica Dust | Y / N Foundry |
| Y / N Woodworker | Y / N Sandblaster | Y / N Ship Yards |
| Y / N Farming | Y / N Carpenter | Y / N Pottery Worker |
| Y / N Radiation | Y / N Painter | Y / N Talc Worker |
| Y / N Railroad Worker | Y / N Insulation Worker | Y / N Asbestos Abatement Worker |
| Y / N Textile Manufacturing | Y / N Beryllium Worker | Y / N Aluminum Worker |
| Y / N Umatilla Army Depot Worker | Y / N Plastic Worker | Y / N Hanford Worker – Wash. State |
| | | Y / N Insulation Product Manufacturing |

Review of Systems: (Please check off any symptom(s) that you are experiencing)

Constitutional:

- Lack of energy
- Weight gain
- Weight loss
- Fevers
- Chills
- Night sweats
- Daytime sleepiness
- Trouble sleeping
- Weakness
- Loud snoring
- Breathing difficulty while sleeping (apnea)

Ophthalmologic:

- Wears glasses/contacts
- Watering/irritation of eyes
- Cataracts
- Glaucoma
- Vision Changes

ENT:

- Difficulty hearing
- Earache
- Buzzing or ringing in ears
- Nasal stuffiness
- Nose bleeds
- Persistent hoarseness
- Sore or bleeding gums
- Sore tongue
- Wears dentures or partials
- Sinusitis

Respiratory:

- Shortness of breath
- Wheezing
- Raises phlegm
- Coughs up blood
- Daily cough
- Asthma
- Emphysema
- Recurrent bronchitis
- Tuberculosis
- Pneumonia
- Fluid around lungs
- Scarring of lungs

Cardiac:

- Chest pain/angina
- Irregular heartbeat/murmur
- High blood pressure
- Heart attack
- Leg swelling/pain
- Circulation problems

Gastrointestinal:

- Poor appetite
- Trouble swallowing
- Painful swallowing
- Heartburn
- Stomach ulcer/pain
- Indigestion
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Hemorrhoids
- Black stools
- Blood in stools
- Jaundice
- Liver problems
- Pancrease problems
- Gallstones
- Vomiting blood
- Hepatitis

Genitourinary:

- Getting up more than once a night to urinate
- Trouble starting stream
- Trouble emptying bladder
- Blood in urine
- Venereal disease
- Kidney or bladder stones
- Impotence

Immune System:

- Multiple infections
- Immune deficiency
- Seasonal allergies

Musculoskeletal:

- Joint pain, swelling or redness
- Arthritis
- Back pain
- Muscle pain
- Gout
- Osteoporosis
- Phlebitis

Dermatologic:

- Rash
- Skin cancer
- Skin infections
- Acne
- Nonhealing ulcer

Endocrine:

- Diabetes
- Thyroid disease
- High cholesterol
- Excessive thirst
- Excessive hunger
- Adrenal gland problems

Hematologic:

- Easy bleeding or bruising
- Anemia
- Clotting disorder
- Previous transfusions
- Blood clots in legs
- Blood cancer

Neurologic:

- Stroke
- Seizures
- Paralysis
- Numbness of hands
- Numbness of feet
- Memory loss
- Loss of consciousness
- Headaches
- Balance problems
- General weakness
- Localized weakness

Psychiatric:

- Hallucinations
- Feeling depressed
- Suicidal thoughts
- Suicide attempt
- Anxiety
- Nervous or upset
- Insomnia

Gynecologic: (Female Only)

- Breast lumps, masses
- Breast cancer
- Recent mammogram
- Recent Pap smear
- Recent pelvic exam
- Menopause
- Hysterectomy
- Hormone therapy
- Birth control pills
- Breathlessness with exertion

Activities of Daily Living: (Are you experiencing any of the following – Circle Y for Yes and N for No?)

- Y / N Difficulty with bathing, dressing or feeding yourself?
- Y / N Difficulty with showering, vacuuming, or bedmaking?
- Y / N Difficulty getting out of chairs or bed?
- Y / N Decreased movement or strength in your arms or legs?
- Y / N Have you fallen in the last month, or have balance problems?
- Y / N Has it been more than 5 years since you obtained a new wheelchair?
- Y / N Do you often choke on food, liquids or pills?
- Y / N Do you have difficulty communicating your needs to others?
- Y / N Decrease in the loudness of your voice or ability to speak clearly?

Patient Medical/Legal Health Care Documents and Directives:

- Y / N Do you have a Living Will or Advance Directive?
- Y / N Do you have an Organ Donor Card designated on your Oregon Driver's license?
- Y / N Do you have a Healthcare Power of Attorney?
- Y / N Full Resuscitation
- Y / N Do Not Resuscitate
- Y / N No ventilator support
- Y / N General Medical Care Only

What are your general thoughts about end of life care? _____

Would you like a copy of our report to go to any other doctors? *(Please List below)*

- 1.
- 2.
- 3.

Please use this space to fill in any details from prior pages where you required extra room for documentation.

Name: _____ Date of Evaluation ___/___/___/

PHYSICIAN MEDICAL DECISION MAKING: (For Medical Personnel Use Only)

Data Reviewed:

- Chest radiographs:**
 - Office (date) _____ Dictated? Yes
 - Outside (date) _____
 - Chest CT Scan (date)** _____
 - Awake oximetry (date)** _____
 - Overnight oximetry (date)** _____
 - Office (date) _____
 - Outside (date) _____
 - VQ Scan (date)** _____
 - PET/SPECT Scan (date)** _____
 - Bronchoscopy (date)** _____
 - PSG/MSLT (date)** _____
 - Blood Tests/Other (specify & date):**

 - Pulmonary Function Tests**
- Spirometry**
 - Office (date) _____
 - Lung Volumes**
 - Office (date) _____
 - Outside (date) _____
 - Diffusing Capacity**
 - Office (date) _____
 - Outside (date) _____
 - Methacholine Challenge Testing**
 - Office (date) _____
 - Outside (date) _____
 - ABG (date)** _____
 - Exercise Stress Testing (date)**_____
 - 6 Minute Walk Test (date)**_____
 - Echocardiogram (date)** _____
 - Thoracentesis (date)** _____

IMPRESSION:

PLAN:

Name: _____ Date of Evaluation ____/____/____/

SPA CLINICIAN NOTES

Chief Complaint/History of Present Illness:

Past Medical History:

Past Surgical History:

Family History:

Social History:

Risk Factors:

Allergies:

Immunizations:

Medications:

