|  |  |
| --- | --- |
| **Last Name:** |  |
| **First Name:** |  |
| **Date of Birth:** |  |
| **Age:** |  |
| **Home Address:** |  |
| **Ethnicity/Race: (Optional)** |  |
| **Marital Status:** | ** Single  Married  Divorced  Separated  Widowed  Other** |
| **Occupation (or prior occupation if not working)** |  |
| **Who referred you to me?** |  |
| **What is the reason for the consultation?** |  |
|  |
| **List your physicians:** **Use additional pages if needed** | **Name** | **Specialty** | **Address** | **Phone #**  |
| **\*\*Check box if provider to receive a copy of today’s consultation**  | ****  |  | Pulmonologist |  |  |
| **** |  | Cardiologist |  |  |
| **** |  | Medical Oncologist |  |  |
| **** |  | Radiation Oncologist |  |  |
| **** |  | Gastroenterologist |  |  |
|  | **** |  | Other |  |  |

Click here to entte.

**MedStar Thoracic Health Program at MedStar Georgetown University Hospital**

3800 Reservoir Road, NW

Pasquerilla Health Center, Fourth Floor

Washington, DC 20007

202-444-7299 **PHONE**

877-376-2421 **FAX**

**MedStar Thoracic Health Program at MedStar Washington Hospital Center**

**110 Irving Street NW**

**Cancer Institute, First Floor**

**Washington, DC 20010**

202-877-8115 **PHONE**

202-877-3699 **FAX**

**MedStar Thoracic Health Program at Reston Hospital Center**

1860Town Center Drive #310

Reston, VA 20190

202-444-7299 **PHONE**

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**Thomas Watson, MD**

**M. Blair Marshall, MD**

**Marc Margolis MD**

**Puja Khaitan, MD**

**John Lazar, MD**

**Hayley Henderson, CRNP**

**Margaret Hamm, CRNP**

**medstarhealth.org**

***Please complete this form and return to our office prior to your appointment. Please fax it to the appropriate fax # for your location. If unable to fax, please bring this form with you to your appointment.***

|  |
| --- |
| Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Pharmacy**  | **Name** | **Address** | **Phone#** | **Fax #** |
|  |  |  |  |  |
|  |
| **Medications** |
| Are you currently taking any medication?If “yes”, please list the medication(s), dosage and times taken per day.Please add a separate sheet if required | ** Yes  No**

|  |  |  |
| --- | --- | --- |
| **Name of medication** | **Dosage** | **Times taken per day** |
|  |  |  |

 |
| **Allergies** |
| Are you allergic to any medications?If “yes”, please name the medications | ** Yes  No** |
| Do you have a **latex allergy**? | ** Yes  No** |
| Do you have other allergies? (such as food or environmental) If yes, please list  | ** Yes  No** **Other allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
|  |
| Have you taken any Aspirin, Advil, Nuprin (or similar medications) in the last 7 days?If “yes”, what is the name of the medication? | ** Yes  No**** Aspirin  Advil  Aleve  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |  |
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|  |  |
| **Medical History- check all that apply and note date diagnosed** |  |
| ** Anemia**** Anesthesia Complications**** Angina**** Anxiety**** Arrhythmia**** Atherosclerosis**** Autoimmune Disease**** Back problems**** Bleeding/Clotting disorder**** Cancer – type\_\_\_\_\_\_\_\_\_\_**** Chronic Bronchitis**** Chronic Renal Failure**** Cirrhosis**** Claudication**** Carotid disease**** Congestive heart failure**** Crohn’s disease**** Deep Vein Thrombosis (Blood Clots)**** Depression**** Diabetes – Type 1**  | ** Diabetes – Type 2**** Diverticulitis Fibromyalgia**** Fibroid Tumors**** Gallstones**** Gallbladder inflammation****Gastric acid reflux****Gastric ulcer****Gastric bleeding****Gout**** Heart attack (MI)**** Hepatitis type: \_\_\_\_\_\_\_**** High blood pressure****Hyperthyroidism**** High cholesterol/lipids**** HIV****Irritable bowel syndrome**** Kidney disease** | **Kidney failure****Kidney stones**** Liver disease****Lupus****Multiple sclerosis****Myasthenia gravis****Multiple Myeloma**** Neuropathy****Obesity****Osteoarthritis** ** Osteoporosis****Obstructive sleep apnea****Joint replacement****Specify: \_\_\_\_\_\_\_****Pancreatitis****Paraplegia/Quadreplegia****Radiation treatment/exposure****Raynard’s syndrome****Rheumatoid arthritis** | **Scleroderma**** Seizure disorder**** Sickle cell disease**** Swelling/edema****Stroke (CVA)****TIA****Transplant****Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_**** Thyroid disorder****Tuberculosis****Ulcerative colitis****Urinary tract infection****Valvular heart disease****Vasculitis****Vericose veins****Venous stasis** |  |
| **Other medical history: please describe**   |  |
| Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Past Surgical History- check all that apply and note the side of surgery and the exact date diagnosed** |  |
| ** Amputation**** Angioplasty**** Aneurysm repair**** Arterial bypass**** Appendectomy**** Bronchoscopy**** Breast surgery**** Bunion removal**** Bypass surgery (CABG)**** Cancer surgery**** Cardiac surgery**** Cataract surgery**** Carotid surgery**** Carpel Tunnel syndrome**** Charcot reconstruction**** Cosmetic surgery**** Cholecystectomy**** Cesearean section**** Gastric Bypass** | ** Gastric banding** ** Hemorrhoids surgery**** Hernia repair – site:** ** Hysterectomy**** Joint replacement – site:**** Dialysis access placement – site/type:**** Transplant – type:**** Nephrectomy**** Nissen fundoplication**** Pacemaker**** Pancreas surgery**** Parathyroidism**** Lung surgery**** Bone/Joint surgery – specify:**** Prostate surgery (TURP)**** Spine surgery**** Vein surgery**** Valve replacement – type:** |  |

|  |
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| **Family History** |
| Do you have a family history of the following disease processes: cancer, high blood pressure, stroke, heart disease, or diabetes? | ** Yes  No** |
| If “yes”, list relative, age and initial diagnosis: |
| Relative | **Paternal/Maternal** **(P) (M)** | Diagnosis / Age at diagnosis | **Current Status of Relative?** | **If deceased, cause and age of death** |
|  | ** P  M** |  | ** Living  Deceased** |  |
|  | ** P  M** |  | ** Living  Deceased** |  |
|  | ** P  M** |  | ** Living  Deceased** |  |
|  | ** P  M** |  | ** Living  Deceased** |  |
|  | ** P  M** |  | ** Living  Deceased** |  |

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| Social History |
| Have you ever smoked? | ** Yes  No** |
| If “yes” indicate duration in years: |

|  |  |  |
| --- | --- | --- |
| Year started | Year stopped | # Packs/day |
|  |  |  |

 |
| Do you exercise regularly?  | ** Yes  No** |
| Do you eat or drink foods containing caffeine? (for example: coffee, tea, soda or chocolate?) | ** Yes  No** |
| If “yes” list average daily consumption: |  |
| Do you drink alcohol? | ** Yes  No** |
| If “yes”, average number of alcoholic drinks/day: |  |
| Do your religious beliefs impact your utilization of health services (e.g. Jehovah’s witness) |  |

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Review of Systems**

 **Please check any of the symptoms that you are experiencing NOW.**

**General Symptoms**

 Loss of appetite

 Weight loss/gain

Specify amount gained/lost in last 3 months

 Fevers or chills

 Dizziness

 Night Sweats

 Other: \_\_\_\_\_\_\_\_\_\_\_

**Respiratory Symptoms**

 None

 Shortness of breath

 Shortness of breath with activity

 Shortness of breath at rest

 Shortness of breath lying flat

 Coughing up blood or sputum

 Wheezing

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal Symptoms**

 None

 Abdominal pain

 Bloos in stool

 Change in bowel habits

 Difficulty/pain with swallowing

 Hiatal hernia

 Indigestion/GERD

 Vomiting blood

 Other: \_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular Symptoms**

 None

 Angina

 Calf pain or cramps when walking

 Heart murmur

 Irregular heart beat

 Wake up out of breath (PND)

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary Symptoms**

 None

 Bladder cancer

 Bladder/Kidney infections

 Blood in urine

 Difficulty urinating

 Enlarged prostate

 Prostate cancer

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Hematologic Symptoms**

 None

 Anemia

 Bleeding/clotting disorder

 Depressed immune system

 Swollen lymph nodes

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal Symptoms**

 None

 Back/spine problems

 Joint pain/stiffness

 Osteoporosis

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological Symptoms**

 None

 Difficulty with speech

 Numbness in arms/hands/legs/feet

 Seizures

 Stroke

 Weakness in arms/hands/legs/feet

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic Symptoms**

 None

 Abnormal bleeding

 Ovarian/Uterine tumors

 Other: \_\_\_\_\_\_\_\_\_\_

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Additional information** |

|  |
| --- |
|  |
| ***Please sign your name:*** | ***Date:*** |
|  |  |
| Reviewed with patient | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Date |

 ***Thank you for taking the time to complete and return this form. Please initial the bottom right corner of each page before returning to our office.***