|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**

877-376-2421 **FAX**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | |  |
| **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:** | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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** |  |

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| 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.***