CARLOS R. SANTOS MD, PA
PULMONARY & SLEEP MEDICINE

Name ______________________ Today's Date __________

Dear Patient:
A few minutes of your time answering the following questions
will help Dr. Santos assess your problem and give you better care.

Which Doctor referred you to Dr. Santos for evaluation:

____

1. Name Medications that you are ALLERGIC to: ____________

It is your problem related to:
Pulmonary ____________ or Sleep Disorder ____________

What is the main reason you are seeing Dr. Santos today:

____

____

____

2. CURRENT MEDICATIONS

Drugs Name	Doses	Frequency

Note: You can attach a list of medications. Thanks

3. REVIEW OF SYSTEM

Please CIRCLE the phrase that describe your situation:

GENERAL: Change in appetite Chills Fatigue Fever Night Sweats Weigh Gain Weigh Loss

SKIN: Rash Acne Dry Skin Excessive Sweating Infection Skin Injury

HEAD: Head Injury Headache Headache Affecting Vision Headache with Nausea and Vomiting

EYES: Blurred Vision Changes in Vision Eye Itching Eye Pain

EARS: Dizziness Hearing Loss Infection Vertigo

NOSE and SINUSES: Frequent Colds Nasal Congestion Nose Bleeding
Runny Nose Sinus Headache Sinus Problem

MOUTH and THROAT: Bleeding Gums Dry Mouth Wear Dentures
White Plaques Sore Throat Hoarseness

NECK: Neck Pain Stiffness Swelling

BREAST: Nipple Discharge Pain Self Breast Exam Recent Mammogram

RESPIRATORY: Chest Pain Cough Shortness of Breath Tuberculosis
Nocturnal Chocking Snoring Wheezing

CARDIAC: Chest Pain High Blood Pressure Edema
Irregular Heart Beat Recent ECG (when)

GASTROINTESTINAL: Abdominal Pain Constipation Diarrhea
Food Intolerance Heart Burn Hemorrhoids Rectal Bleeding

MUSCULOSKELETAL: Arthritis Back Pain Gout Joint Pain
Muscle Cramps

HEMATOLOGIC: Anemia Bleeding Blood Transfusion

PERIPHERAL VASCULAR: Cr31llps Thrombophlebitis Varicose Veins

NEUROLOGIC: Incoordination Memory Loss Numbness Syncope

PSYCHIATRIC: Anxiety Depression Hallucination Insomnia
Irritability Nervousness Panic Episodes

ENDOCRINE: Cold Intolerance Heat Intolerance Excessive Hunger
Excessive Sweating Unusual Hair Loss

SLEEP DISORDER: Wake up at night Shocking or Gasping Insomnia
Snoring Day Time Sleepiness Wake up at Night to go to Restroom

4. MEDICAL HISTORY

	Year
1. Any Kind of Cancer________________________________	________________
2. Glaucoma________________________________	________________
3. Asthma________________________________	________________
4. Tuberculosis________________________________	________________
5. HTN________________________________	________________
6. Valvular Heat Disease________________________________	________________
7. High Cholesterol________________________________	________________
8. Esophageal Reflux________________________________	________________
9. Ulcer Stomach________________________________	________________
10. Rheumatoid Arthritis________________________________	________________
11. Migraine________________________________	________________
12. Stroke________________________________	________________
13. Depression________________________________	________________
14. Anxiety________________________________	________________
15. Allergic Rinithis________________________________	________________
16. Pneumonia________________________________	________________
17. Diabetes________________________________	________________
18. Gout________________________________	________________
19. Lupus________________________________	________________
20. Trauma________________________________	________________
21. Sleep Apnea________________________________	________________

4.1 SURGICAL HISTORY

List of Surgeries you ever have had and year

Surgery	Year

5. FAMILY HISTORY

5.1 In your family some one have had: CIRCLE

- Cancer
- Sleep Apnea
- Diabetes
- Asthma
- Hypertension
- Heart Disease

5.2 About your parents

	Alive	Diseased	Age	Reason
Father				
Mother				

6. SOCIAL HISTORY

6.1 Have you ever smoke: Yes No

6.1.1 If Yes a what age did you started: ____________________

6.1.2 If you quit: At what age did you quit: ____________________

6.1.3 How many per daily: ____________________

6.2 Do you drink alcohol: Yes No

6.3 Marital Status: Single Married Divorce Widowed

6.4 What is your occupation: ____________________

6. PROCEDURES

	Year		Year
Chest X-Ray	________	CT-Scan	________
V/Q Scan	________	PFT (Breathing Test)	________
Bronchoscopy	________	EKG	________
Holter	________	Echo	________
Stress Test	________		________