PULMONARY HISTORY

Resident Name: _____ Physician: _____

Room Number: _____ Med Record #: _____

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TB SKIN TEST HISTORY

TYPE	DATE	RESULTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHEST X-RAY

DATE	RESULTS
_____	_____
_____	_____
_____	_____

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Reason for Pulmonary History: ____ New Resident ____ Annual Screening ____+PPD

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Please respond to each listed symptom with a check in the appropriate box:

YES	NO	
_____	_____	Completed preventive treatment. If yes, give dates: From: _____ to: _____ and # of months on treatment: ___
_____	_____	A cough exists. If yes, is it: ___ Productive or ___ Non-Productive
_____	_____	Night sweats
_____	_____	Hemoptysis (spitting up blood)
_____	_____	Smoker: If yes, number of years: _____
_____	_____	Weight loss: How many lbs.? ____ In how many months? _____
_____	_____	Chest pains
_____	_____	Fever
_____	_____	Weakness/Tired/General malaise
_____	_____	Loss of appetite
_____	_____	Difficulty in breathing
_____	_____	Recent URI prolonged - 7-10 days

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Additional history/risk factors referral information:

_____

_____

Signature: The information given is true to the best of my knowledge. The general symptoms of the disease and reason for screening and surveillance test have been explained and appropriate referrals offered.

M.D. _____ Date _____