PULMONARY HISTORY

Resident Name: __________________________  Physician: ___________________________

Room Number: __________________________  Med Record #: _______________________

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TB SKIN TEST HISTORY

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CHEST X-RAY

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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:

_____________________________________________________________________________

_____________________________________________________________________________

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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 _______________________