

Peter D. Buckman, M.D., F.A.C.S.

Patient Name: _____ Date of Visit: ____/____/____

Patient Age: _____ SS #: ____ / ____ / ____ Referring Doctor: _____

1. What is the reason for this office visit? _____

2. Please list all of your medications and their dosages:

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

3. **Medication allergies:** _____

4. Please check any illnesses that you have been diagnosed with or treated for:

- | | | |
|-------------------------------|------------------------------|---------------------------|
| _____ High Blood Pressure | _____ Heart Valve Disease | _____ Diabetes |
| _____ Diabetes | _____ Emphysema | _____ Stroke |
| _____ Heart Attack | _____ Anemia | _____ HIV/AIDS |
| _____ Kidney Failure | _____ Cirrhosis of the liver | _____ Ulcers |
| _____ Hiatal Hernia/GE reflux | _____ Diverticulitis | _____ GI Bleeding |
| _____ Prostate Enlargement | _____ Arthritis | _____ Aneurysm |
| _____ Vascular Disease | _____ Collapsed Lung | _____ Cancer, Type: _____ |

Other illness: _____

5. Please check any surgeries that you have had:

- | | | |
|------------------------------|------------------------------|-------------------------|
| _____ Lung surgery – R / L | _____ Valve Replacement | _____ Joint Replacement |
| _____ Aneurysm Surgery | _____ Heart Bypass | _____ Hysterectomy |
| _____ Leg Bypass | _____ Pacemaker | _____ Appendix |
| _____ Carotid Artery Surgery | _____ Prostrate: TURP/Cancer | _____ Gall Bladder |

Other surgery: _____

6. Do you smoke: _____ **Yes** _____ **Quit: When?** _____ _____ **Never**
_____ # packs per day _____ # packs per day _____ Pipe
_____ # years smoking _____ # years smoking _____ Cigars

7. Do you drink alcohol? _____ No _____ Rarely _____ Yes: How much? _____

8. Is there any history in your immediate family of serious illness?

- | | | |
|---------------------------|--------------------|----------------|
| _____ High Blood Pressure | _____ Heart Attack | _____ Diabetes |
| _____ Emphysema | _____ Aneurysm | _____ Stroke |
| _____ Cancer: Type? _____ | | |
| _____ Other _____ | | |

9. If surgery is recommended, would you prefer Henrico Doctors Hospital or Saint Mary's Hospital?

10. Primary Care Physician _____ Pulmonologist _____
Cardiologist _____ Oncologist _____
Other Physicians: _____

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Thoracic Surgery

Patient Questionnaire II

Name _____ Date ____/____/____

Please check any of the following symptoms that you have experienced:

General/Constitutional

___ Weight loss: How many pounds over how many months _____

___ Weight Gain ___ Fatigue ___ Fevers ___ Chills ___ Sweats

Eyes/Ears/Nose/Throat

___ Headaches: Location _____ Duration _____ Precipitating factors _____

___ Blurred Vision ___ Vertigo ___ Lightheadedness ___ Nose bleeding

___ Dental difficulties ___ Dentures ___ Neck stiffness/pain ___ Neck lumps

Cardiovascular

___ Chest pain; location _____ Sharp or dull? _____ ___ palpitations

___ Heart murmur ___ Shortness of breath when lying down ___ varicose veins

___ Leg pain with walking ___ leg swelling

Respiratory

___ Pain with breathing ___ Cough ___ Coughing up blood ___ Wheezing

___ Sleep apnea ___ Mucous: Circle: Clear/yellow/brown/red/green

___ Shortness of breath at rest ___ Shortness of breath with exertion

Can you walk up one flight of steps? ___ Yes ___ No

Genitourinary

___ Sudden need to urinate ___ Frequent urination ___ Painful urination ___ Bloody urine

___ Up at night to urinate ___ Excessive urine ___ Decreased urine ___ Infections

___ Kidney Stones ___ Unusual color of urine ___ slow urine, change in stream

___ Incontinence

Gastrointestinal

___ Loss of appetite ___ Indigestion ___ Food intolerances ___ Trouble swallowing

___ Abdominal pain ___ Nausea ___ Vomiting ___ Vomiting up blood ___ jaundice

___ Constipation ___ Diarrhea ___ Hemorrhoids ___ Bad Breath

___ Bringing up undigested foods ___ Abnormal stools ___ Recent changes in bowel habits

Musculoskeletal

___ Pain, swelling, redness of muscle or joints ___ limited motion ___ weakness

___ Muscle atrophy ___ Muscle cramps ___ Back pain

Neurologic/Psychiatric

___ Convulsions/Seizures ___ Tremors ___ Incoordination ___ tingling

___ Difficulties with memory ___ Difficulty with speech ___ Hallucinations

___ Sensory of motor disturbances ___ Muscular incoordination ___ Mini-strokes

___ Nervousness ___ Emotional problems ___ Anxiety ___ Depression

Allergic/Immunologic/Endocrine

___ Reactions to drugs, foods or insects ___ Anemia ___ Bleeding tendencies

___ Prior transfusions ___ Local or general lymph node tenderness or enlargement

___ Intolerance to heat or cold