GEORGIA
Pulmonary & Critical Care
CONSULTANTS

Frank J. DeMarco, Jr., M.D.

MEDICATION LIST

Name: _____ **DOB:** _____

Allergies:_____

Date: _____ **Medication:**	**Updated:**	**Updated:**	**Updated:**

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1505 Northside Blvd., Suite 3000
Cumming, GA 30041
TEL (770) 886-0036 • FAX (770) 886-6677

HISTORY AND REVIEW OF SYSTEMS

Name: _____ Date: _____ Age: _____
Date of Birth: _____ Referring Doctor: _____
Reason for the visit: _____
Date of your most recent:
Chest X-Ray: _____ Where: _____
CT Scan: _____ Where: _____
Pulmonary Function: _____ Where: _____
Bloodwork: _____ Where: _____

Past Medical History

Have you ever Had:	YES	NO
Asthma		
Hayfever		
COPD		
Pneumonia		
Sinusitis		
Tuberculosis		
Sarcoidosis		
High Blood Pressure		
Coronary Artery Disease		
Angina		
Heart Attack		
Congestive Heart Failure		
Peripheral Vascular Disease		
Carotid Artery Disease		
Rheumatic Fever		
Stroke/TIA		
Sleep Apnea		
Arthritis		
GERD (reflux)		
Ulcers		
Liver Disease		
Kidney Disease		
Anemia		
Measles		
Mumps		
Chicken Pox		
Whooping Cough		
Other		

Past Surgical History

	YES	NO
Coronary Artery Bypass		
Heart Valve		
Pacemaker		
Defibrillator		
Lung Surgery		
Tonsilectomy		
Gall Bladder		
Joint Replacement		
Other		

Are you on oxygen therapy? ☐ Yes ☐ No
What provider: _____
How long have you been using? _____

Are you using a CPAP/BiPAP? ☐ Yes ☐ No
What provider: _____
How long have you been using? _____

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Family History

	If living, age and health status	Major Illnesses: (Cancer. Diabetes, Heart Disease, etc.)	If deceased, age and cause of death
Father			
Mother			
Brothers/Sisters			
Sons/Daughters			

Social History:

Birthplace: _____ Marital Status: Married / Single / Divorced / Widowed

Previous Smoker: When: _____ How long: _____ Date stopped: _____

Smoker: ☐ Yes ☐ No if yes: Packs per day: _____ How long: _____

Alcohol Use: ☐ Yes ☐ No if yes: How much: _____

Occupation: _____

Indoor Pets: _____ if yes, what type: _____

Review of Systems: Do you have any of the following symptoms?

	YES	NO
Fever		
Chills		
Night Sweats		
Weight gain or loss		
Chest pain		
Palpitations		
Swelling in ankles		
Cough		
Shortness of breath		
Wheezing		
Indigestion		
Abdominal pain		
Bloody stools		
Difficulty swallowing		
Pain with urination		
Snoring		
Daytime Sleepiness		
Muscle/Joint Pain		

Reviewed by: _____ Date: _____