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Ocala Health
Heart & Lung Surgery

****Please complete the following items as completely as possible****

Patient Name: _____

DOB: _____ Primary Care Physician: _____

Preferred Pharmacy Name (Include Phone #) : _____

Cardiologist (Include Phone#): _____

Pulmonologist (Include Phone#): _____

Oncologist (Include Phone#): _____

Review of Symptoms : Please check YES or NO. Are you experiencing any of the following ***today*** ?

Fever	☐ YES	☐ NO	Weakness	☐ YES	☐ NO
Chills	☐ YES	☐ NO	Dizziness	☐ YES	☐ NO
Sweats	☐ YES	☐ NO	Headache	☐ YES	☐ NO
Chest Pain	☐ YES	☐ NO	Blurred Vision	☐ YES	☐ NO
Palpitations	☐ YES	☐ NO	Hearing Loss	☐ YES	☐ NO
Abdominal Pain	☐ YES	☐ NO	Ear Pain	☐ YES	☐ NO
Nausea	☐ YES	☐ NO	Sore Throat	☐ YES	☐ NO
Vomiting	☐ YES	☐ NO	Cough	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO	Wheezing	☐ YES	☐ NO
Constipation	☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO
Joint Pain	☐ YES	☐ NO	Pain with Urination	☐ YES	☐ NO
Muscle Pain	☐ YES	☐ NO	Decreased Urination	☐ YES	☐ NO
Joint Swelling	☐ YES	☐ NO	Increased Urination	☐ YES	☐ NO
Back Pain	☐ YES	☐ NO	Rash	☐ YES	☐ NO
Skin Lesion	☐ YES	☐ NO			

Date of last Mammogram, if applicable: _____

Date of last Colonoscopy, if applicable: _____

Have you received the flu shot: _____

Have you received the pneumonia vaccine: _____

Have you or someone you know traveled outside the US in the last 3 months? YES NO