Dignity Health.
Pacific Central Coast Health Centers
Med Plus

Med Plus Atascadero, 5920 W. Mall, Atascadero
Med Plus Central Coast, 2271 S. Depot St., Santa Maria
Med Plus Pismo Beach, 877 Oak Park Blvd., Pismo Beach

Respiratory Physical Exam

Patient Name_____DOB _____ Today's Date _____
Employer_____ Position_____ SSN _____
BP _____/_____ P _____ R _____ Height_____Weight_____
Email Address _____

Have You Had Or Do You Have?

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Skin Sensitivities	☐	☐	Tuberculosis
☐	☐	Heart Murmur / Rheumatic	☐	☐	Impaired Sense of Smell	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Psychological Problems	☐	☐	Chronic Cough
☐	☐	Pneumonia	☐	☐	Chest Surgery / Injury	☐	☐	Fear of enclosed areas
☐	☐	Emphysema	☐	☐	Hay Fever	☐	☐	Problems using a respirator
☐	☐	Bronchitis	☐	☐	Allergies	Do you get short of breath?		
☐	☐	Pleurisy	☐	☐	Ruptured Eardrum	☐	☐	Waiting on Level Ground
☐	☐	Other Heart / Lung	☐	☐	Hearing Loss	☐	☐	Climbing Stairs
☐	☐	Fainting Spells	☐	☐	Sinus Problems	☐	☐	With Exercise
☐	☐	Anemia	☐	☐	Diabetes	Do you smoke?		
☐	☐	Alcoholism	☐	☐	Heart Stroke	☐	☐	If yes, how much_____

Yes	No	The following is to be documented prior to the pulmonary function test, if any of the answer are yes, the test may need to be rescheduled.
☐	☐	1. Within the past hour, have you smoked or used an inhaler?
☐	☐	2. Within the past two hours, have you eaten a heavy meal?
☐	☐	3. Are you under the care of a physician for any illness at this time?
☐	☐	4. In the past three weeks, have you had any respiratory infections, such as flu, pneumonia, bronchitis or a cold?
☐	☐	5. Do you have any allergy symptoms now, or have you in the past three months?
☐	☐	6. Are you presently taking any medications? If yes, please list names_____

_____

To Be Completed by Examiner

Spirometry Check List

Equipment: _____ _____ _____ _____
Name Model Serial Number Date of Calibration
Position of patient during test: ☐ Standing ☐ Sitting Effort: ☐ Good ☐ Fair ☐ Poor Ambient Temperature _____

Review of Information

Vision (without correction) _____ _____ Previous PFT results (most recent) _____ _____ _____
Right Eye Left Eye FEV 1%Pred. FVC% Pred. FEV1/FVC%

Chest Radiograph Report (most recent)_____

Physical Examination

Ears (TM intact): ☐ Right Ear ☐ Left Ear

Facial Configuration: ☐ Normal ☐ Receding Chin ☐ Hair ☐ Beard ☐ Moustache ☐ Other _____

Respiratory

Distress: ☐ No ☐ Yes, please describe _____

Chest Configuration: ☐ Normal ☐ Kyphosis ☐ Scoliosis ☐ Other _____

Auscultation: ☐ Normal ☐ Decreased: Locally/Generally Adventitious Sounds: ☐ Wheezing ☐ Rales ☐ Rhonchi Clubbing: ☐ No ☐ Yes

Use of accessory muscle: ☐ No ☐ Yes Cardiac: ☐ Rhythm ☐ Murmurs ☐ Other _____

Respirator Approval ☐ Not approved ☐ Approved ☐ Approved for use of _____

Comments_____

Provider Signature _____ **Name** _____ **Date** _____