MEDICAL HISTORY

Date: _____ Requesting Physician: _____

Name: _____ Last chest x-ray, when and where done

DOB: _____ Age: _____ _____

Height: _____ Weight: ____ Sex: __ Race: _____ MEDICATION ALLERGIES

Marital Status: ____ Children: _____ _____

Educational Level: _____ _____

Current Occupation: _____ _____

Employer: _____ _____

Occupational Exposure: _____ Medications You Are Currently Taking

	Name	Dose	Times/Day
Past Occupations: _____	_____	_____	_____
_____	_____	_____	_____
List Date and Types of Surgeries:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had a recent flu vaccination? When and where _____

PULMONARY HISTORY

1. Do you ever have shortness of breath? _____
   Is there anything that makes it worse? _____
   Is there anything that makes it better? _____

2. Do you have a cough? _____ How long have you had the cough? _____
   Describe the cough. _____
   Is there anything that makes the cough worse? _____
   Is there anything that makes the cough better? _____

3. Do you bring up sputum? _____ What color? _____ How often? _____

4. Have you ever had blood in the sputum? _____ When? _____

5. Does you're chest feel tight or uncomfortable? ____ Is there anything that makes it worse? _____
   Is there anything that makes it better? _____

6. Do you sleep well at night? _____ Do you snore? _____

7. Have you ever had a sleep study? _____ When and where? _____

8. Do you smoke now? _____ Have you ever smoked? _____ How many years? _____
   How much did you smoke per day on average? _____
   Age when you started?_____
   Age when you stopped?_____

9. Do you have sinus trouble? _____ Is it worse any certain time of year? _____

10. Have you had allergy testing? _____ By whom? _____ When? _____

11. Has a doctor ever told you that you have lung problems of any kind, and if so, what? _____

12. Have you ever been exposed to anything that might be harmful to your lungs such as dust, chemicals, fumes, asbestos, pesticides, etc? _____
    _____

13. As a child did you have any unusual illnesses (other than normal childhood diseases)? _____

14. Have you ever had or been exposed to tuberculosis (TB)? _____
    If so, when? _____ Have you ever had any treatment for TB? _____
    Date of your last TB skin test. _____ Results _____

15. Do you drink alcohol and if so, how much? _____

16. Do you have pets in your home? _____

17. Have you ever had birds, chickens or unusual pets? _____

<u>FAMILY HISTORY</u>

Father Living Yes _____ No ____ Mother Living Yes ___ No _____
Siblings How many? _____
Brothers ___Living Yes___ No ____ Sisters____ Living Yes____ No _____
Children Total live births? _____
Boys _____ Living Yes ____ No ____ Girls ____ Living Yes ___ No _____

Do any of them have or have had in the past:
Cancer _____ Who? M F S C Type_____
High Blood Pressure ___ Who? M F S C Diabetes_____ Who? M F S C
Heart Problems _____ Who? M F S C Lung Problems__ Who? M F S C

List date, name of hospital and reason for hospitalization (other than surgery)

_____
_____
_____

Please explain in your own words the reason for your visit.

_____

_____

_____

REVIEW OF SYSTEMS

Please check if you have/had problems related to the areas indicated.

	YES	NO
1. CONSTITUTION		
Weight change		
Fevers		
Sweats		
Fatigue		
2. EYES		
Glaucoma		
Cataracts		
Vision surgery		
3. EARS, NOSE, THROAT		
Loss of hearing		
Dizziness		
Nose bleeding		
Gum bleeding		
4. RESPIRATORY		
COPD		
Wheezing		
Chronic cough		
Bronchitis		
Shortness of breath		
Asthma		
Pneumonia		
5. CARDIOVASCULAR		
Heart Attack		
Hypertension		
Chest pain/angina		
Heart murmur		
Anemia		
Transfusions		
Phlebitis or blood clots		
Rheumatic fever		
6. GASTROINTESTINAL		
Reflux		
Hepatitis A		
Dysphagia		
Hernia/repair		
Gall bladder disease		

	YES	NO
7. ENDOCRINE SYSTEM		
Diabetes		
Thyroid problem		
Hormone treatment		
8. BREAST/GENITAL		
Menopause		
Masses		
Genital infections		
9. URINARY SYSTEM		
Urinary tract/bladder infection		
Kidney stones		
Incontinence		
Trouble urinating		
Prostrate problems		
10. SKIN		
Cancers		
Rashes		
11. NEUROLOGIC		
Stroke		
Seizures		
Head injury		
Nerve Damage		
12. PSYCHIATRIC		
Anxiety		
Depression		
13. MUSCULOSKELETAL		
Osteoarthritis		
Rheumatoid Arthritis		
Gout		
14. CANCER – TYPE _____		
OTHER_____		
_____		
_____		
_____		

The information provided in this form is true and complete to the best of my knowledge.

Patient signature _____

The nurse will thoroughly go over your history with you before you are seen by the doctor so if you feel we need to cover something else you will have time to explain this.

Updated (date) _____ _____ _____

Form reviewed by physician: _____ Date: _____