



DIVISION OF PULMONARY & CRITICAL CARE ASSOCIATES

Medical History Form

DATE _____

Name _____ Date of birth _____
Last First MI

What lung problem do you want us to help you with:

Who is your family doctor? _____

SOCIAL HISTORY:

Single [] Married [] Divorced [] Widowed []

Number of Children _____

Race/Ethnic Background:

American Indian or Alaska Native []	Asian []
Black or African American []	Hispanic or Latino []
Native Hawaiian/Other Pacific Islander []	White []
Choose not to disclose/Declined []	Unknown []

Country of Birth: US [] Other _____

Are you currently: Working [] Retired []
Unemployed [] Disabled []

Occupation(s)

Most Recent First (including former careers if you are retired or not working):

1) _____

2) _____

3) _____

4) _____

Leisure Activities: _____

Please answer these questions with regard to your CURRENT HEALTH STATUS

DIFFICULTY BREATHING (Hard to breathe, chest tightness, short of breath)

How long have you been bothered by shortness of breath? _____

How far can you walk on level ground at your own pace **without stopping?**
 (for example: 20feet, ½ block, 3 blocks, 1 mile, etc.) _____

How many **flights** of stairs can you walk without stopping?

Please circle: 0 ½ 1 2 3 or more **flights** of steps

- | | Yes | No |
|---|------------|-----------|
| Do you get short of breath when you lay down in bed?
How often? _____ | [] | [] |
| Do you wake up in the middle of the night short of breath?
How often? _____ | [] | [] |
| Do you wake up in the morning short of breath?
How often? _____ | [] | [] |
| Do you have to walk slower than people of your age on the level
<u>because</u> of breathlessness? | [] | [] |
| Do you wheeze or make noise when you breathe?
How often? _____ | [] | [] |

What **situations or places or activities** make your **shortness of breath** worse?

- | | | | |
|---------------|-----|------------------------------|-----|
| Dust or fumes | [] | | |
| Tobacco smoke | [] | Weather changes/humidity | [] |
| Wood smoke | [] | Perfumes | [] |
| Exercise | [] | Emotions | [] |
| Cold air | [] | Household cleaning solutions | [] |

Places you get short of breath _____

Other things that will make you short of breath _____

Things that make it better _____

COUGH

- | | Yes | No |
|------------------------------|------------|-----------|
| Do you cough frequently? | [] | [] |
| Do you cough some every day? | [] | [] |

If not every day, how often? _____

How many years have you been coughing? _____

- | | | |
|--|-----|-----|
| Do you cough up phlegm (sputum) when you do cough? | [] | [] |
| Every day, or most days? | [] | [] |
| Every week? | [] | [] |
| 3 months out of the year? | [] | [] |
| Other? _____ | | |

Do you usually bring up some phlegm first thing in the morning? [] []

How many years have you been coughing up phlegm? _____

Have you ever coughed up bloody phlegm? [] []

How often? _____

How much? _____

CHEST PAIN

Yes No

Do you have pain in the chest? [] []

Only during activity? [] []

At rest during the day? [] []

At night? [] []

Other? _____

If you have chest pain, how often does it happen?

Every day? [] []

Several times per day? [] []

Every week? [] []

Other? _____

If you have chest pain, where is it? (Right, left, center, front, back, etc)

TOBACCO USE-CIGARETTES

Yes No

Have you **ever** smoked cigarettes regularly? (More than 20 packs of cigarettes in a lifetime, or more than one cigarette a day for one year.) [] []

Do you **still** smoke? [] []

Do you have a plan to quit? [] []

Do you want help to quit? [] []

How old were you when you first started regularly smoking cigarettes? _____

Age

If you stopped smoking completely, how old were you when you stopped? _____

Age

How many cigarettes per day do (did) you smoke on an average? _____

Cigarettes/Day

For how many years altogether have you smoked? _____ yrs

Yes No

Do you smoke **cigars?** [] []

Do you smoke **a pipe?** [] []

Do you chew tobacco? [] []

PAST TESTS:

	Yes	No
Have you had a chest Xray?	[]	[]
When was the last time? _____		
Where? _____		
 Have you had Pulmonary Function Tests (breathing tests)?	 []	 []
When? _____		
Where? _____		
 Skin test for tuberculosis? (PPD, mantoux, or tuberculin test)	 []	 []
Positive___ Negative___ Unknown___		

Have you had these immunizations (or Vaccinations)? Please check the following:

Tetanus shot	[]
Hepatitis	[]
Pneumovax (“Pneumonia shot”)	[]
Influenza vaccine (“Flu shot”)	[]
Every year?	[]

ALLERGIES

	Yes	No
Have you ever been told by a doctor that you have allergies?	[]	[]
Have you ever had allergy tests ?	[]	[]
When? _____		
Where? _____		
Have you ever had allergy shots ?	[]	[]
When? _____		
Have you ever been told you have hay fever ?	[]	[]

ENVIRONMENTAL ALLERGIES (Medication Allergies are listed separately)

SUBSTANCE	SYMPTOM
(such as pollen, mold, eggs, food, animals, etc.)	(such as rash, difficulty breathing, wheezing, etc.)

MEDICATION ALLERGIES (or medications you can not tolerate)

MEDICATION	SYMPTOM
(such as penicillin, iodine, etc.)	(allergy - rash, difficulty breathing) (intolerant - nausea, vomiting)

CURRENT MEDICATIONS: Prescription Medications

<u>NAME</u>	<u>AMOUNT</u>	<u>REASON</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Non-Prescription Medications or Dietary Supplements/Herbs/Vitamins

MEDICAL HISTORY:

	Yes	No
Asthma	[]	[]
Emphysema	[]	[]
Pneumonia	[]	[]
Tuberculosis	[]	[]
Other lung diseases	[]	[]
Treated for sinusitis	[]	[]
Postnasal drainage	[]	[]
Nasal polyps	[]	[]
Allergy to Aspirin	[]	[]
High blood pressure	[]	[]
Heart Failure	[]	[]
Angina (Heart Pain)	[]	[]
Heart Attack	[]	[]
Abnormal Heart Rhythm	[]	[]
Other Heart Disease	[]	[]

Other Medical Problems / Hospitalizations (past or present):

Operations-Surgeries / Approximate Dates:

FAMILY HISTORY:

Mother: [] Alive - current age_____ or [] Died – age at time of death_____

Medical Problems/Cause of Death

Father: [] Alive - current age_____ or [] Died – age at time of death_____

Medical Problems/Cause of Death

Sisters: Number Living___ Number Died_____

Medical Problems/Cause of Death

Brothers: Number Living___ Number Died_____

Medical Problems/Cause of Death

Has anyone in your family (grandparents, aunts, uncles, brothers and sisters, parents, children) had any of these medical problems?:

Asthma: _____

Emphysema: _____

Lung Cancer: _____

Blood Clots in the Lungs: _____

Other Lung Diseases: _____

Diabetes: _____

Heart Problems: _____

High Blood Pressure: _____

Other Medical Problems in your family that you think are important:

What type of building do you live in?

Apartment _____ House _____ Mobile home _____ Other _____

How long have you lived in this building? _____

Age of Building _____ years (approximate 5, 10, etc.)

Are you aware of any water problems in your home? _____

Heat: Forced Air _____ Hot Water Baseboard _____ Other _____ (please specify)

Air Conditioning: Central _____ Room _____ None _____

Pets: Cats _____ Dogs _____ Birds _____ Other _____

Neighborhood Air Pollution _____ (Chemical Plant, Factory, etc.)

Review of Systems

General:

- Fever
- Chills
- Weight loss ____# over _____(time)
- Weight gain ____# over _____(time)
- Loss of appetite
- Unusual fatigue or loss of energy

Eyes:

- Visual problems _____
- Excessive Tearing

Ears, Nose, Mouth, Throat:

- Hearing loss
- Ringing in ears
- Pain or pressure in ears
- Nasal drainage
- Difficulty swallowing
- Hoarseness
- Snoring

Cardiovascular/Heart :

- Irregular heart beats
- Swelling in legs
- Pain in legs when walking

Gastrointestinal:

- Heartburn
- Hiatal Hernia
- Reflux Esophagitis / GERD
- Nausea
- Vomiting
- Stomach Ulcers

Skin:

- Rashes
- Change in color of mole
- Other _____

Genitourinary:

- Kidney or Bladder Problems
- Frequency of urination
- Burning with urination
- Blood in urine
- Abnormal vaginal bleeding

Hematology/Lymphatic:

- Abnormal bleeding
- Abnormal bruising
- Swollen glands
- Anemia

Neurologic:

- Trouble with walking or balance
- Seizures or convulsions
- Numbness and tingling
- Difficulty with speech
- Headaches
- Daytime sleepiness

Psychiatric/Emotional:

- Anxiety
- Depression
- Mood swings

Endocrine:

- Diabetes
- Thyroid problems
- Hotter____ or colder____ than others

Musculoskeletal/ Bones and Joints:

- Arthritis
- Pain or swelling in joints
- Joint stiffness
- Muscle weakness