Pulmonary Internists, PA

MEDICAL HISTORY

Date: ___/___/___ Name: _____ Birth date: ____/___/___

Chief Complaint: _____

_____

Allergies to Medications, X-Ray Dyes, Other Substances: Yes No
If yes, please list name and type of reaction: _____

_____

Current Medications: _____

_____

History of Present Illness: _____

_____

Where is the location of the Problem? _____
Describe the quality (character) of the symptom/pain? _____
How severe is the symptom/pain (scale of 1 - 10) with 10 being severe? _____
How long does the symptom last? _____
Does the pain/symptom occur at a specific time? _____
Is there a particular situation when the symptom/pain occurs? _____
Is there anything that you do that makes the symptom/pain better or worse? _____

_____

Are there any other associated signs or symptoms when the symptom/pain occurs? _____

_____

Please List and Supply the Dates of:
Operations: _____

_____

Hospitalizations other than for surgery: _____

_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____Length of period: _____
Pregnancies: _____ Births: _____Miscarriages: _____
Prolonged or abnormal bleeding: ___No ___Yes Please describe: _____
Leakage of urine: ___No ___Yes Please describe: _____
Pelvic pain: ___No ___Yes Please describe: _____
Abnormal discharge: ___No ___Yes Please describe: _____
History of abnormal Pap smear: ___No ___Yes Please describe: _____

Past Medical History and Review of Systems

circle all that apply

High blood pressure	Hay fever	Headaches
Diabetes	Abdominal discomfort	Kidney disease
Cancer	Indigestion	Kidney stones
Heart disease	Nausea	Difficulty Urinating
Chest pain/tightness	Vomiting	Arthritis
Shortness of breath	Constipation	Low back problems
Swollen ankles	Diarrhea	Skin Diseases
Palpitations	Blood in stool	Blood disorders
Lightheadedness	Ulcers	Venereal Diseases
Frequent urination	Changes in bowel habits	Anxiety
Rheumatic fever	Unexplained weight gain/loss	Depression
Asthma	Hemorrhoids	Anemia

Bronchitis	Hepatitis or jaundice	Alcohol abuse
Pneumonia	Gall bladder disease	Drug abuse
Persistent cough	Colitis	Gout
T.B.	Thyroid disease	Headaches
Hay fever	Head or neck radiation	Loss of consciousness
Other		

Family History: Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age at diagnosis
Cancer (describe type)	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other:	_____	_____

Prevention

Do you wear seat belts? Yes No
Do you wear a bike helmet? Yes No N/A
Do you smoke? Yes No If yes, how many packs per day? _____
Have you quit smoking? Yes No If yes, when? _____
Do you drink alcoholic beverages? Yes No If yes, how much per week?_____
Do you drink coffee? Yes No If yes, how many cups per day?_____
Do you drink tea? Yes No If yes, how many cups per day?_____
If there is a gun in your home, do your keep it unloaded and out of children's reach? Yes No ____N/A
Do you use drugs? (marijuana, cocaine etc) Yes No If yes, explain:
Have you ever engaged in any activity which has put you at risk of getting AIDS? Yes No If yes, explain:
Do you wish to be tested for AIDS? Yes No
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Yes No
If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Yes No
Do you feel afraid of your partner? Yes No N/A
Do you have a "living will"? Yes No
Do you have a donor card? Yes No
Method of birth control?

Immunization history - Have you had: Pneumovax immunization? Yes No When?
Hepatitis B? Yes No When? Flu immunization? Yes No When?
Tetanus immunization? Yes No When? Other? Yes No When?

When was your last:
Pap smear? Mammogram? P.P.D. (TB skin test)? Breast exam?
Cholesterol check? Stool check for blood? Prostate exam?