PERSONAL MEDICAL HISTORY

Reason for Visit: _____

Review of Symptoms (Please check any that have been active in the past 2 weeks):

General

- Fever ❑
- Fatigue ❑
- Drenching Night Sweats ❑
- Weight Gain ❑
- Weight Loss ❑

Skin

- Severe Bruising ❑
- Hives ❑

HEENT

- Glaucoma ❑
- Nasal Congestion ❑
- Sleep Apnea ❑
- Seasonal Allergies ❑
- Sinus Pain ❑
- Snoring ❑

Neck

- Neck Mass ❑
- Neck Swelling ❑

Respiratory

- Bloody Sputum ❑
- Acute Cough ❑
- Difficulty breathing with Exertion ❑
- Wheezing ❑
- Sputum/phlegm ❑

Cardiovascular

- Chest Pain ❑
- Edema ❑
- Heart Stint ❑
- Irregular Heart Beat ❑
- Palpitations ❑

Gastrointestinal

- Change in Bowel Habits ❑
- Difficulty Swallowing ❑
- Heartburn ❑
- Black or Bloody Stools ❑

Musculoskeletal

- Backache ❑
- Leg Cramps ❑
- Leg pain when walking ❑

Neurological

- Attention Deficit ❑
- Decreased Memory ❑
- Difficulty Speaking ❑

Psychiatric

- Anxiety ❑
- Depression ❑
- Hypersomnia/ sleepiness ❑
- Insomnia ❑

Allergies (include any environmental allergies such as grass or pollen and any medication and/or food allergies): _____

_____

Immunizations: PPD ❑ Date: _____ Flu ❑ Date: _____ Pneumonia ❑ Date: _____

Immediate Family History:

Please check if any immediate blood relatives have had any of the following

- COPD ❑
- Asthma ❑
- Emphysema ❑
- Tuberculosis ❑
- Lung Cancer ❑
- High Blood Pressure ❑
- Heart Disease ❑
- Stroke ❑
- Diabetes ❑
- Sleep Disorder ❑

Is your mother Living ❑ Deceased ❑ Cause of Death? _____

Is your father Living ❑ Deceased ❑ Cause of Death? _____

Social History:

Do you have any pets? Yes ❑ No ❑ If yes, type of pet(s): _____

History of Tobacco Use:

Do you smoke? Yes ❑ No ❑ Have you ever smoked? Yes ❑ No ❑

Type of Tobacco: _____ # of Packs Per Day: _____

Year Starting Smoking: _____ Year Quit Smoking: _____ Exposure to Second Hand Smoke? Yes ❑ No ❑

Medications (please list all medications that you are currently taking, including over-the-counter medications and vitamins):

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recent Diagnostic Studies:

Chest X-Ray Date: _____ CT/PET: Date _____ Sleep Study: Date: _____

Asbestos History/Occupational History:

Have you ever been exposed to asbestos? Yes No If yes, when and for how long? _____

Please list your current and past occupations: _____

_____

Past Medical History (Please check any that apply):

COPD	❑	Sleep Apnea	❑
Asthma	❑	Restless Legs	❑
Emphysema	❑	Lung Cancer	❑
Tuberculosis	❑	Coronary Disease	❑
Pneumonia	❑	Atrial Fibrillation	❑
Respiratory Failure	❑	Cardiomyopathy	❑
Pulmonary Embolism	❑	Stroke or Paralysis	❑
DVT	❑	High Blood Pressure	❑
Pleural Effusion	❑	Diabetes	❑
Bronchitis – Recurrent	❑	Other Cancer	❑

Surgical History

Please check if you have been hospitalized or had surgery for:

Lung Surgery	Yes	❑	No	❑	If yes, when: _____
Heart Surgery	Yes	❑	No	❑	If yes, when: _____
Abdominal Surgery	Yes	❑	No	❑	If yes, when: _____
Tonsillectomy	Yes	❑	No	❑	If yes, when: _____
Sleep Apnea Surgery	Yes	❑	No	❑	If yes, when: _____

Other Major Hospitalizations or Surgeries: _____

_____

Chart #: _____