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: 20 feet, 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 **because** 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 our 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

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 a day?	[ ]	[ ]
Every week?	[ ]	[ ]
Other? _____		

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

TOBACCO USE-CIGARETT ES

	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 have 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

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

MEDICATION ALLERGIES (or medications you can not tolerate)

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

CURRENT MEDICATIONS: Prescription Medications

NAME	AMOUNT	REASON

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 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, 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 _____ Home _____ Mobile home _____ Other _____

How long have you lived in this building? _____