PULMONARY MEDICINE

MEDICAL HISTORY FORM

Name_____ Date_____ Age_____

DRUG ALLERGIES

_____ _____

_____ _____

HOSPITALIZATIONS

Date	Reason	Where

FAMILY HISTORY

Have any members of your family had the following:

	Father	Mother	Siblings	Children	Grandparents
Heart Disease	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑
Pneumonia	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑

HABITS

Smoke: Packs Daily _____

How Long? _____

When Stopped? _____

Exercise Routine: _____

Coffee: Cups Daily _____

Other Caffeines _____

Alcohol:Type/Amount _____

PAST MEDICAL HISTORY

❑ Asthma
❑ Chronic Obstructive Pulmonary Disease
❑ Emphysema
❑ Chronic Bronchitis
❑ Allergies/Hay Fever
❑ Pneumonia
❑ Tuberculosis
❑ Recurrent Pulmonary Infections
❑ Other Respiratory Disorders
❑ Chest Pain
❑ Pleurisy
❑ Shortness of Breath
❑ Chronic Cough
❑ Coughing Up Blood
❑ Fever/Night Sweats
❑ Sinus Infections
❑ Gastroesophageal Reflux
❑ Scarlet Fever
❑ Rheumatic Fever
❑ Hepatitis
❑ Peptic Ulcer
❑ Diabetes
❑ Gout
❑ Heart Murmur
❑ Heart Palpitations
❑ Hypertension
❑ Congestive Heart Failure
❑ Depression
❑ Nervousness
❑ Chronic Rashes
❑ Chronic Obesity
❑ Snoring
❑ Insomnia
❑ Weight Change
❑ Cancer
❑ Wheezing
❑ Headaches

PRESENTING SYMPTOMS

❑ Cough _____

Onset _____ Duration _____

Type _____ Time of Day _____

Sputum _____ Color _____

How Much Do You Cough Up? _____

❑ Shortness of breath when lying down, exertion, or sitting

❑ Chest Pain

❑ Swelling of the hands or feet

❑ Wheezing

❑ Reduced activity level

❑ Discoloration of Nailbeds or Lips

Occupational Exposures _____

Occupation_____