

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
 Pneumonia
 Persistent cough
 T.B.
 Hay fever
 Other

Hepatitis or jaundice
 Gall bladder disease
 Colitis
 Thyroid disease
 Head or neck radiation

Alcohol abuse
 Drug abuse
 Gout
 Headaches
 Loss of consciousness

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 you 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?

Wellness Quick Screen

How would you rate your health on a scale if 1 to 4? (1=excellent to 4=poor) _____

Have you stayed overnight as a patient in a hospital or gone to an emergency room more than 2 times in the past 12 months? _____

Are you taking 7 or more medications including over-the-counter? _____

Did you lose or gain 10 or more pounds without trying in the past 6 months? _____

Do you often feel sad, downhearted, or blue? _____

Do you need someone to help with activities of daily living (ADL's)? _____

Are you renting or using medical equipment like a wheelchair, oxygen, or a hospital bed? _____

Do you have home care services like a nurse, therapist, or home health aide? _____

Have you seen more than 3 specialty doctors? (not a dentist, eye doctor, of podiatrist) _____

Have you fallen more than once in the past 12 months? _____

Do you currently smoke cigarettes or other tobacco products? _____

Do you wear contact lenses or glasses? _____

Do you have difficulty reading or watching TV, even with corrected vision? _____

Have you completed an advanced medical directive? _____

Have you had a flu shot in the last 12 months? _____

Have you ever had a pneumococcal pneumonia shot? _____

Do you need someone to help you take your medication? _____

Have you had a Pap test in the past 12 months? _____

Have you had a mammogram in the past 12 months? _____