

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.

It will help your physician to know not only about your health, but also about your family and relatives

TODAY'S DATE

NAME		ADDRESS		City	Zip Code
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TELEPHONE NUMBER	DATE OF BIRTH	AGE	RACE OR NATIONALITY OF PARENTS	SEX M F	HEIGHT Ft In	WEIGHT Lbs.
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WHO REFERRED YOU TO US? _____ WHO IS YOUR **PRIMARY CARE DOCTOR**? _____

WHAT IS YOUR MAIN MEDICAL PROBLEM YOU ARE HERE FOR, AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

PAST MEDICAL HISTORY

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD:
 Asthma Bronchitis Emphysema Pneumonia Tuberculosis Lung Cancer Bronchiectasis Allergy
 Pneumothorax Hiatal Hernia Sinusitis Gastroesophageal Reflux Bleeding Tendency Kidney Disease Stroke
 High Blood Pressure Diabetes Heart Disease (angina, arrhythmias or a heart attack) Nervous Illness Rheumatic Fever
 Glaucoma Sleep Apnea Other: _____

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

HAVE YOU HAD AN ALLERGY OR SENSITIVITY TO MEDICATIONS OR OTHER SUBSTANCES?
 No Yes \Rightarrow LIST: _____

MEDICATIONS including over-the-counter medication (Include all inhaled medication)

SOCIAL HISTORY

RELIGION	EDUCATION (Highest level attained)	OCCUPATION \Rightarrow	HOW LONG
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PRESENT MARRIAGE (Year married)	HAVE YOU HAD 2 nd HAND SMOKE EXPOSURE? <input type="checkbox"/> No <input type="checkbox"/> Yes \Rightarrow	EXPLAIN
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WHAT TYPES OF HOBBIES OR RECREATIONAL ACTIVITIES DO YOU HAVE? _____

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S AND CANADA?

HAVE YOU EVER HAD A JOB WHICH EXPOSED YOU TO: DUSTS FUMES ASBESTOS SANDBLASTING
 CHEMICALS OTHER? Please explain amount and duration of exposure:

DO YOU USE TOBACCO NOW? <input type="checkbox"/> No <input type="checkbox"/> Yes	IN THE PAST? <input type="checkbox"/> No <input type="checkbox"/> Yes	TYPE AND DAILY AMOUNT	HOW LONG? yrs	WHAT YEAR DID YOU QUIT? _____
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DO YOU USE ALCOHOLIC BEVERAGES ? <input type="checkbox"/> No <input type="checkbox"/> Yes \Rightarrow	TYPE	WEEKLY AMOUNT	HOW LONG?
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DO YOU DRINK COFFEE ? <input type="checkbox"/> No <input type="checkbox"/> Yes \Rightarrow	WEEKLY AMOUNT	HOW LONG?
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DO YOU HAVE ANY PETS? <input type="checkbox"/> No <input type="checkbox"/> Yes \Rightarrow	NUMBER AND TYPE _____ DOG(S) _____ CAT(S) _____ BIRD(S) OTHER _____
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CONTINUE ON BACK

FAMILY HISTORY

ALIVE ☺ DECEASED ☹	FATHER <input type="checkbox"/> Age _____ <input type="checkbox"/> Age _____	Present health or cause of death	MOTHER <input type="checkbox"/> Age _____ <input type="checkbox"/> Age _____	Present Health or cause of death	SPOUSE <input type="checkbox"/> Age _____ <input type="checkbox"/> Age _____	Present Health or cause of death
BROTHERS ☺	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
SISTERS ☺	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
CHILDREN ☺	NO. ALIVE	AGES AND HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH		

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** AND SPECIFY RELATION

(**M** = mother; **F** = father; **B** = brother; **S** = sister; **A** = Aunt; **U** = uncle; **GMF** = grandmother on father's side; etc):

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|--|--|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cystic fibrosis _____ | <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Alpha 1-antitrypsin deficiency (A1AT) _____ | <input type="checkbox"/> Bleeding Tendency _____ | <input type="checkbox"/> Nervous Illness _____ |
| <input type="checkbox"/> Sarcoidosis _____ | <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Allergy _____ |
| <input type="checkbox"/> Interstitial lung disease (IPF) _____ | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ | |

REVIEW OF SYSTEMS

HAVE YOU HAD ANY OF THE FOLLOWING SIGNS OR SYMPTOMS:

Constitutional

- Weight Loss Excess Fatigue Fever
- Chills Night Sweats Weakness
- Anorexia

Eyes

- Glasses/contacts Vision Changes
- Double vision Blurred vision
- Pain Discharge Excessive tearing

ENT/Mouth

- Earache Tinnitus Discharge
- Hearing Loss Popping Post-nasal drip
- Hoarseness Bad breath Swelling
- Sore Throat Bleeding gums
- Toothache Oral lesions Dentures

Cardiovascular

- Chest pain Angina Palpitations
- Murmur Claudication
- Shortness of breath after going to sleep

Respiratory

- Cough Sputum Production
- Coughing Up Blood Chest Pain
- Wheezing Sinus Congestion Asthma
- Frequent respiratory infections
- Stopping Breathing at Night
- Daytime Sleepiness Unrestful sleep
- Morning Headaches Obstructive Sleep Apne

Gastrointestinal

- Heartburn Nausea or Vomiting
- Diarrhea Constipation
- Blood in Stool Blood in Vomit
- Food Intolerance Stomach ulcers
- Laxative use Gas/Indigestion
- Hepatitis Hernia Rectal Bleed/pain
- Polyps Colitis Diverticulitis (-osis)
- Abdominal Pain Trouble Swallowing

Genito-urinary

- Burning on urination
- Frequency of urination
- Urination after going to sleep
- Urgency of urination Dribbling
- Blood in urine Infections

Musculoskeletal

- Joint pain Varicose veins
- Claudication Back pain Swelling
- Joint stiffness

Endocrine

- Hot flashes Hair loss
- Temp intolerance Goiter Diabetes

Skin and / or Breast

- Itching Rash Lesions
- Color changes Dermatitis Eczema
- Breast lump, pain, bleeding or discharge

Blood / Lymphatics

- Easy Bruisability Anemia
- Bleeding
- Swollen / painful lymph nodes

Allergy / Immunology

- AIDS Chronic steroids
- Recurrent infections Allergies
- Hives

Neurologic

- Numbness or Tingling
- Tremor Fainting
- Headaches Muscle Weakness
- Paralysis Dizziness Seizures
- Memory Loss Strokes
- Unconsciousness

Psychiatric

- Depression Anxiety
- Insomnia Sexual problems
- Therapy Nightmares

Signature: _____