

Internist Associates of Central New York
Pulmonary Disease Medical History Form



Name _____ Date of Exam _____
Age _____ Date of Birth _____

Reason for today's visit: _____

Who is your primary or family physician? _____

List all the physicians you see on a regular basis and the reason for this:

1. _____ 3. _____
2. _____ 4. _____

List all current and past health problems. None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List Current Medications (Include inhalers, birth control) (List name, dose, frequency). None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Check if you use any of the following devices. None

- Oxygen Flow rate _____ L/min When do you use it? _____
 CPAP or BiPAP (mask worn when sleeping)
 Spacer with inhaler (aerochamber, ellipse, inspirese, etc.)
 Nebulizer (breathing treatment via a machine)

List All Over-the-counter Medications or Supplements (Vitamins, natural herbs, etc.). None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any Allergies to Medications (include IV contrast) or Foods and the Reaction. None

1. _____ 3. _____
2. _____ 4. _____

List All of Your Lifetime Surgeries and Major Injuries. None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List Hospitalizations other than for surgeries and illnesses listed above. None

1. _____ 3. _____
2. _____ 4. _____

Advanced Directives

Do you have an Advanced Medical Directive / Living Will? Yes No

Social History

Highest education level? Grade ____ High School Vocational School
 College Graduate School

Marital Status? Married Single Divorced Widow/Widower

Do/did you smoke? Yes No Packs / day ____ How many years? ____
Have you ever quit? Yes No If yes, when and for how long did you quit? ____
How did you quit? _____

Do you use tobacco products other than cigarettes? Yes No
If yes, which ones? _____

Does anyone smoke in your household? Yes No

Do you drink alcohol? Yes No Amount per week _____

Have you ever used illegal substances? Yes No

Have you ever had a DUI or DWI? Yes No

Have you ever experienced difficulty with alcohol, drug, or other substance use? Yes No

Hobbies? (list) _____
Do you explore caves? Yes No

Pets (types)? _____
Do you take care of birds (pigeons, chickens)? Yes No

Recent Travel (where)? _____

Where did you grow up? _____
Did you live on a farm? Yes No

Occupational History

Current occupation _____

Please list previous occupations (include approximate dates of employment)

- 1. _____ 3. _____
- 2. _____ 4. _____

Exposures: List industrial/agricultural agents/fumes/chemicals to which you have had significant exposure

- 1. _____ 3. _____
- 2. _____ 4. _____

Family History (blood related kin)

Adopted or do not know family history

If your mother or father is deceased, what caused his/her death? _____

If any of you siblings are deceased, what caused his/her death? _____

Please check if any of the following apply to blood related kin. Indicate which family member(s):

- | | |
|--|--|
| <input type="checkbox"/> COPD / emphysema _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Cancer (what type?) _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Bleeding/clotting problem _____ |
| <input type="checkbox"/> Sleep disorders _____ | <input type="checkbox"/> Nasal / Sinus Disease _____ |
| <input type="checkbox"/> Other lung diseases (specify) _____ | |

REVIEW OF SYSTEMS - Do you **CURRENTLY** or **FREQUENTLY** suffer from or have difficulty with any of the below? Please check box(es).

GENERAL

- Unusual fatigue
- Loss of appetite
- Fevers or chills
- Nights sweats (drench sheets/clothes)
- Weight loss. How much? _____ lbs.
Over what time frame? _____
- Weight gain. How much? _____ lbs.
Over what time frame? _____
- None of the above**

EARS, NOSE, THROAT, MOUTH

- Headache
- Ear pain / pressure
- Sinus problems, post nasal drip
- Nasal congestion, runny nose
- Hoarseness
- Frequent need to clear throat
- Ulcer of tongue or mouth
- Sore throat
- None of the above**

ALLERGIC

- Hay Fever
- Frequent sneezing
- Watery eyes
- Seasonal allergies
- None of the above**

GLANDULAR (LYMPHATIC)

- Swollen lymph nodes anywhere
- None of the above**

URINARY

- Blood in urine
- Kidney or bladder problems
- None of the above**

CARDIOVASCULAR

- High blood pressure
- Chest pain on exercise (angina)
- Irregular beat or palpitation of heart
- Heart murmur
- Swelling or edema of ankles
- History of heart attack
- History of enlarged heart (CHF)
- None of the above**

LUNGS (RESPIRATORY)

- Asthma, wheezing
- Cough for more than 3 weeks
- Cough, new problem
- Cough up blood
- Chest tightness or discomfort
- Tuberculosis / PPD + (positive skin test)
- Exposed to tuberculosis
- COPD / emphysema
- Recurrent bronchitis
- Shortness of breath
- Exposure to asbestos or other occupational hazard
- Required life support /mechanical ventilation (respirator)
- None of the above**

STOMACH AND BOWELS

- Difficult or painful swallowing
- Acid Reflux ("Heartburn")
- Regurgitation
- Belching
- Hiatal hernia
- Stomach ulcer / Intestinal ulcer
- Abdominal pain
- Nausea or vomiting
- Vomit blood / Black bowel movements
- Blood or mucous in the stool
- Liver disease
- Hepatitis
- Jaundice
- None of the above**

REVIEW OF SYSTEMS, continued - Do you **CURRENTLY** or **FREQUENTLY** suffer from or have difficulty with any of the below? Please check box(es).

HEMATOLOGIC

- Easy bleeding / bruising
- Anemia (low blood count)
- Ever had a blood clot in legs or lungs
- Blood transfusion
- None of the above**

ENDOCRINE

- Increased thirst, hunger
- Sensitive to heat/cold
- Change in skin, body hair
- None of the above**

MUSCLES AND BONES

- Pains or swelling of joints
- Morning stiffness
- Leg or arm swelling
- Arthritis
- Sexually transmitted diseases
- None of the above**

RHEUMATOLOGIC

- Hair loss
- Joint pains or swelling
- Muscle pain or weakness
- Back or neck pain
- Sharp pain when take a deep breath (pleurisy)
- Dry eyes (eye irritation), dry mouth
- Jaw pain or pain with chewing
- Fingers that turn white and hurt in the cold
(Raynaud's phenomenon)
- None of the above**

SLEEP

- Snoring
- Stop breathing when sleeping
- Fall asleep easily during the day
- None of the above**

SKIN

- Rash
- Tumor on skin
- None of the above**

NEUROLOGIC

- Anxiety
- Depression
- Unusual dizziness, fainting, or loss of consciousness
- None of the above**

IMMUNIZATIONS

(Check if you have received the following)

- Flu shot (influenza) Year: _____
- Pneumovax Year: _____

FOR PHYSICIAN (only) "I have personally reviewed and confirmed the above information."

Signature _____

Date _____