Heritage Valley Pulmonology and Sleep Medicine

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD?

YOU	YOUR FAMILY		YOU	YOUR FAMILY	
_____	_____	ALCOHOLISM	_____	_____	HIGH BLOOD PRESSURE
_____	_____	ANEMIA	_____	_____	KIDNEY DISEASE
_____	_____	ANXIETY ATTACKS	_____	_____	LIVER DISEASE
_____	_____	ARTHRITIS	_____	_____	LUNG DISEASE
_____	_____	ASTHMA	_____	_____	MENTAL DISORDER
_____	_____	CANCER	_____	_____	PHLEBITIS
_____	_____	DEPRESSION	_____	_____	SEIZURES
_____	_____	DIABETES	_____	_____	STROKE/HEART ATTACK
_____	_____	DRUG ABUSE	_____	_____	THYROID DISEASE
_____	_____	GLAUCOMA	_____	_____	ULCER
_____	_____	HEART DISEASE	_____	_____	OTHER_______________

PERSONAL AND SOCIAL HISTORY:

MARITAL STATUS: S M W D

OCCUPATION_______________

EDUCATION_______________

FOREIGN TRAVEL_______________

HOBBIES_______________

SLEEP HABITS_______________

PETS_______________

SMOKING_______________

ALCOHOL USE_______________

CAFFEINE USE_______________

DRUG USE_______________

EXERCISE_______________

BLOOD TRANSFUSIONS_______________

ALLERGIES_______________

PAST MEDICAL HISTORY: LIST OPERATIONS/ HOSPITALIZATIONS; ACCIDENTS/INJURIES

DATE	PROBLEM	HOSPITAL	DOCTOR

HAVE YOU EVER HAD THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_____ MEASLES

_____ GERMAN MEASLES

_____ MUMPS

_____ CHICKEN POX

_____ WHOOPING COUGH

_____ PNEUMONIA

_____ RHEUMATIC FEVER

WHEN WAS YOUR LAST EKG? _______________ WHERE? _______________

WHEN WAS LAST CHEST X-RAY? _______________ WHERE? _______________

IMMUNIZATIONS: CHECK THOSE THAT YOU HAVE HAD. NOTE THE MOST RECENT YEAR RECEIVED.

_____ POLIO 19___ 20___

_____ FLU 19___ 20___

_____ PNEUMONIA 19___ 20___

_____ RUBELLA 19___ 20___

_____ OTHER 19___ 20___

_____ TETANUS 19___ 20___

CURRENT MEDICATIONS: PLEASE LIST PRESCRIPTION MEDICINES; BIRTH CONTROL PILLS, AND VITAMINS YOU TAKE WITHOUT A PRESCRIPTION. INCLUDE DOSAGES.

REVIEW OF SYSTEMS:

PLEASE (X) IF YOU HAVE OR HAVE HAD

_____ DIFFICULTY WITH EYES/EARS/NOSE/THROAT
_____ FREQUENT/CHRONIC COUGH
_____ SHORTNESS OF BREATH
_____ COUGHING OF BLOOD
_____ NIGHT SWEATS
_____ RECENT CHILLS OR FEVERS
_____ PAIN WITH BREATHING
_____ IRREGULAR HEARTBEAT
_____ SWELLING OF HANDS/FEET/ANKLES
_____ CHEST/ARM PAIN
_____ DIFFICULTY SWALLOWING

_____ INDEGESTION
_____ VOMITED BLOOD
_____ CONSTIPATION/DIARRHEA
_____ HEMORRHOIDS
_____ BLOODY OR DARK STOOLS
_____ BURNING, BLOOD, OR PUSS IN URINE
_____ KIDNEY STONES
_____ FREQUENT, SEVERE, HEADACHES
_____ LOSS OF CONSCIOUSNESS
_____ CONVULSIONS/EPILEPSY
_____ RECENT WEIGHT LOSS/GAIN: ____ POUNDS

REVIEWED:

DATE:________________________ SIGNATURE____
DATE:________________________ SGNATURE____
DATE:________________________ SIGNATURE____
DATE:________________________ SGNATURE____
DATE:________________________ SIGNATURE____
DATE:________________________ SGNATURE____

UPDATED: 12/16/10
3/9/01
8/08/08