

HISTORY FOR PULMONARY EVALUATION

Name: _____ **Date:** _____

Please answer the following questions and supply the requested information the best you can. This will assist the doctor in evaluating your problems and also serves as a reminder of questions you might like to ask. Thank you.

I. PAST MEDICAL HISTORY: Check if answer is YES and list year of illness:

Have you ever had:	Check if Yes	Year	Have you ever had:	Check if Yes	Year
Anemia	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____	Meningitis	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Mumps	<input type="checkbox"/>	_____
Back Problems	<input type="checkbox"/>	_____	Nose bleeds	<input type="checkbox"/>	_____
Bladder infection	<input type="checkbox"/>	_____	Pleurisy	<input type="checkbox"/>	_____
Bleeding tendency	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	_____
Blood transfusion	<input type="checkbox"/>	_____	Polio	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	_____	Rheumatic fever	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Sexual problems	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Sleep Apnea	<input type="checkbox"/>	_____
Diphtheria	<input type="checkbox"/>	_____	Thyroid disease	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	_____	TB exposure	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	_____	Ulcer disease	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	_____	Valley fever	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	_____	Other:		_____
Hypertension	<input type="checkbox"/>	_____			_____
Infectious mono	<input type="checkbox"/>	_____			_____
Measles	<input type="checkbox"/>	_____			_____
Malaria	<input type="checkbox"/>	_____			_____

II. FAMILY HISTORY:

Has any blood relative had any of the following:	Check if yes	(list what family member)
Allergy	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____
Bleeding tendency	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	_____
Crippling arthritis	<input type="checkbox"/>	_____
Seizure	<input type="checkbox"/>	_____
Cancer (WHAT TYPE)	<input type="checkbox"/>	_____
Chronic diarrhea	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	_____
Leukemia	<input type="checkbox"/>	_____
Mental illness	<input type="checkbox"/>	_____
Overweight	<input type="checkbox"/>	_____
Peptic ulcer	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	_____

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III. SURGICAL HISTORY:

Check if answer is YES and list year of procedure:

		Year			Year
Appendix	<input type="checkbox"/>	_____	Lung	<input type="checkbox"/>	_____
Back	<input type="checkbox"/>	_____	Nasal Polyps	<input type="checkbox"/>	_____
Breast	<input type="checkbox"/>	_____	Prostate	<input type="checkbox"/>	_____
Bronchoscopy	<input type="checkbox"/>	_____	Sterilization	<input type="checkbox"/>	_____
Cystoscopy	<input type="checkbox"/>	_____	Stomach	<input type="checkbox"/>	_____
Gall bladder	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____	Tonsils/ Adenoids	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	_____	Varicose veins	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	_____	Other:	_____	

IV. ALLERGY HISTORY:

Drugs/Medication (Please list all drug allergies)

V. IMMUNIZATION HISTORY:

		Year			Year
BCG	<input type="checkbox"/>	_____	Flu	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	_____	Tetanus	<input type="checkbox"/>	_____
Other	_____				

VI. PRESENT MEDICATION

(ANY MEDICATIONS TAKEN REGULARLY)

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VIII. SMOKING HISTORY

(Circle type of tobacco)

Cigarette	Cigar	Pipe	Chewing Tobacco	
Year started smoking:	_____	_____	_____	Year quit smoking: _____
I am presently smoking	_____	_____	_____	per day.

X. DRINKING HISTORY

Coffee:	_____	Cups per day
Tea:	_____	Cups per day
Soft Drinks:	_____	Cups per day
Alcohol:	_____	Ounces per day

XII. WEIGHT HISTORY

My usual weight is: _____ pounds
Maximum weight obtained: _____ pounds

XIV. DRINKING HISTORY

Marital Status: M D W S (circle one)
Ages of children: _____
Occupation: _____
Any exposure to toxic chemicals or fumes (e.g. asbestos) _____