Desert Pulmonary & Sleep Consultants, PLC

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

Have you ever had:	No	Yes	YEAR	Have you ever had:	No	Yes	YEAR
Anemia	☐	☐	____	Measles	☐	☐	____
Arthritis	☐	☐	____	Malaria	☐	☐	____
Asthma	☐	☐	____	Kidney disease	☐	☐	____
Back Problems	☐	☐	____	Meningitis	☐	☐	____
Bladder infection	☐	☐	____	Mumps	☐	☐	____
Bleeding tendency	☐	☐	____	Nose bleeds	☐	☐	____
Blood transfusion	☐	☐	____	Pleurisy	☐	☐	____
Bronchitis	☐	☐	____	Pneumonia	☐	☐	____
Cancer	☐	☐	____	Polio	☐	☐	____
Diabetes	☐	☐	____	Rheumatic fever	☐	☐	____
Diphtheria	☐	☐	____	Sexual problems	☐	☐	____
Emphysema	☐	☐	____	Sleep Apnea	☐	☐	____
Gout	☐	☐	____	Thyroid disease	☐	☐	____
Hay fever	☐	☐	____	Tuberculosis	☐	☐	____
Hepatitis	☐	☐	____	TB exposure	☐	☐	____
Heart disease	☐	☐	____	Ulcer disease	☐	☐	____
Hypertension	☐	☐	____	Valley fever	☐	☐	____
Infectious mono	☐	☐	____				

Other: ____

II. FAMILY HISTORY

Has any blood relative had any of the following:	No	Yes	Which family member(s)?
Allergy	☐	☐	____
Anemia	☐	☐	____
Asthma	☐	☐	____
Bleeding tendency	☐	☐	____
Bronchitis	☐	☐	____
Crippling arthritis	☐	☐	____
Seizure	☐	☐	____
Cancer (WHAT TYPE)	☐	☐	____
Chronic diarrhea	☐	☐	____
Diabetes	☐	☐	____
Emphysema	☐	☐	____
Gout	☐	☐	____
High blood pressure	☐	☐	____
Hay fever	☐	☐	____
Heart disease	☐	☐	____
Leukemia	☐	☐	____
Mental illness	☐	☐	____
Overweight	☐	☐	____
Peptic ulcer	☐	☐	____
Thyroid problems	☐	☐	____

Name: ______________________ **Date:** ______________________

III. SURGICAL HISTORY

Type of surgery:	No	Yes	YEAR	Type of surgery:	No	Yes	YEAR
Appendix	☐	☐	____	Lung	☐	☐	____
Back	☐	☐	____	Nasal Polyps	☐	☐	____
Breast	☐	☐	____	Prostate	☐	☐	____
Bronchoscopy	☐	☐	____	Sterilization	☐	☐	____
Cystoscopy	☐	☐	____	Stomach	☐	☐	____
Gall Bladder	☐	☐	____	Thyroid	☐	☐	____
Heart	☐	☐	____	Tonsils/Adenoids	☐	☐	____
Hernia	☐	☐	____	Varicose veins	☐	☐	____
Hysterectomy	☐	☐	____				

Other: ______________________

IV. ALLERGY HISTORY (PLEASE LIST ALL DRUG/MEDICATION ALLERGIES)

______________________ ______________________
______________________ ______________________
______________________ ______________________

V. IMMUNIZATION HISTORY

	No	Yes	YEAR		No	Yes	YEAR
Pneumonia	☐	☐	____	Tetanus	☐	☐	____
Flu	☐	☐	____	Other____________			____

VI. PRESENT MEDICATION

Medication	Dosage	Medication	Dosage

VII. SMOKING HISTORY (CIRCLE TYPE OF TOBACCO)

Cigarette Cigar Pipe Chewing Tobacco

Year started smoking: ____________ Year quit smoking: ____________

I am presently smoking ______________________ per day.

VIII. DRINKING HISTORY

Coffee: ____________ Cups per day Soft Drinks: ____________ Cups per day

Tea: ____________ Cups per day Alcohol: ____________ Ounces per day

IX. WEIGHT HISTORY

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

X. SOCIAL HISTORY

Marital Status: **M D W S** (circle one)

Ages of children: ____ ____ ____ ____ ____ ____ ____

Occupation: ______________________

Year of arrival in Arizona: ____________ Total years lived in Arizona: ____________

Any exposure to toxic chemicals or fumes (e.g. asbestos) ______________________

{05/10 shl}