

PATIENT NAME \_\_\_\_\_ Date \_\_\_\_\_ Sex M F

**Current Medications**

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Name</i>	<i>Dose</i>	<i>Frequency</i>

<i>Allergies to Medications</i>	<i>Type of Reaction</i>	<i>Allergies (Other)</i>	<i>Type of Reaction</i>

**Past Medical History**

<i>Medical Problem</i>	<i>Date</i>	<i>Surgical Procedure</i>	<i>Date</i>

<i>Hospitalization</i>	<i>Location</i>	<i>Date</i>

**Tests and Immunizations**

<i>Item (Most Recent)</i>	<i>Yes</i>	<i>Year</i>	<i>No</i>
Chest X-Ray/Chest			
EKG			
Exercise Treadmill			
Allergy Skin			
Flu Vaccine			

<i>Item (Most Recent)</i>	<i>Yes</i>	<i>Year</i>	<i>No</i>
Pneumonia Vaccine			
Pulmonary			
Sleep Study			
Sinus X-Ray/CT			
TB (PPD) Skin Test			

## Family History

<u>System</u>	<u>Diseases</u>	<u>Family Member/Age</u>
Respiratory	Emphysema/COPD Asthma TB Other	
Heart	Heart attack Heart bypass surgery Valvular heart disease Hypertension Stroke	
Endocrine	Diabetes Thyroid Other	
Cancer	Lung Breast Gastrointestinal Other	

## Social History

### Past/Present Occupations:

Smoking History      Number of cigarettes/packs per day: \_\_\_\_\_  
Cigars    Y    N  
Number of years smoked \_\_\_\_\_  
If quit, (Date) \_\_\_\_\_

Alcohol History      Number of drinks per day/week: \_\_\_\_\_

Marital Status:                    S      M      D      W

Highest level of education:

Pets:

Exercise:

With whom do you live?

Patient Name \_\_\_\_\_ Date \_\_\_\_\_