HEALTH HISTORY

You have been scheduled for an appointment with ***Critical Care and Pulmonary Consultants, P.C.*** This health history will help us facilitate your evaluation and allow you to think about the answers to questions that you will be asked during your visit. Please fully complete this health history and bring it to your appointment. Thank you for your cooperation!

Name: _____ Date of Birth: _____

REFERRING PHYSICIAN INFORMATION

Referring physician is the individual to whom correspondence will be sent.

Referring or Primary Care Physician:

_____

Name

_____

Address

_____

City, State, Zip Code

(____) _____ (____) _____

Phone Fax

Other Physician:

☐ Please check this box if you would like us to send correspondence

_____

Name

_____

Address

_____

City, State, Zip Code

(____) _____ (____) _____

Phone Fax

REASON FOR VISIT:

Briefly describe the reason for your visit and what you hope to accomplish:

Pharmacy Information

Name: _____ **Phone #:(____)** _____ **Fax#:(____)** _____

MEDICATIONS

Please list your current oral and inhaled medications including medication name, dose, and number of times per day you take the medication, and mark whether you take it "regularly" or only "as needed." Please list any "over the counter" medications including any vitamins and herbs.

Medication (Oral and Inhaled)	Tablet strength or # puffs	# of Times per Day	Regular Use	Only "as needed"	Comments
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
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			☐	☐	
			☐	☐	
			☐	☐	

Do you use Oxygen? ☐ YES ☐ NO **(**If **YES**, Please mark **ALL** that apply)

Time of Day	Date Started	Liters/minute	Comments
☐ Sleep			
☐ Activity			
☐ Continuous			
☐ Other			

Name of Home Health / Oxygen Company: ______

Drug Allergies / Adverse Drug Reactions If **none**, please **CHECK HERE** ☐

Name of Medication	Reaction	Comment

Are you allergic to **EGGS**? ☐ YES ☐ NO ☐ DO NOT KNOW
Are you allergic to **IODINE**? ☐ YES ☐ NO ☐ DO NOT KNOW
Are you allergic to **CONTRAST DYE**? ☐ YES ☐ NO ☐ DO NOT KNOW

Immunizations (Please mark **ALL** that apply)

Type	Date	Comment
☐ Pneumonia Vaccine		
☐ Flu Shot		

Have you ever had skin testing or allergy shots? ☐ YES ☐ NO ☐ DO NOT KNOW

PAST MEDICAL HISTORY (Please mark **ALL** that apply)

Diagnosis	Month/Year Onset	Diagnosis	Month/Year Onset
☐ Asthma		☐ Congenital Heart Disease	
☐ Bronchitis		☐ Abnormal EKG	
☐ Emphysema		☐ Diabetes	
☐ COPD		☐ Stroke	
☐ Hay Fever		☐ Cancer/type	
☐ Sinus Disease		☐ Blood Clots	
☐ Pneumonia		☐ Pulmonary Embolism	
☐ Interstitial Lung Disease		☐ Deep Vein Thrombosis	
☐ Pulmonary Fibrosis		☐ Bleeding disorder	
☐ Hives (urticaria)		☐ Liver Disease	
☐ Tuberculosis or + PPD test		☐ Hepatitis	
☐ Atypical mycobacterial dis.		☐ Kidney Disease	
☐ Bronchiectasis		☐ Sleep Apnea	
☐ Chronic Cough		☐ Insomnia	
☐ Heart Attack		☐ Heartburn/GERD	
☐ High Blood Pressure		☐ Trauma	
☐ Chest Pain/Angina		☐ High Cholesterol	
☐ Heart Murmur		☐ Other	
☐ Congestive Heart Failure		☐ Other	

Have you ever been **hospitalized**? ☐ YES ☐ NO If so, for what reason?

Admission date	Diagnosis/Problem	Length of stay	Comments

Please list any **surgeries** you have had and the approximate date of the surgery.

Surgery Date	Type of Surgery	Comments

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed

Occupation:

Any history of toxin or chemical exposure related to current or former occupation or hobbies? ☐ Yes ☐ No

If so, please describe

Smoking History:

- ☐ Never smoker
- ☐ Current or Former smoker
  - Age started Age stopped
  - Average # packs per day
  - Current # packs per day
- ☐ Other Tobacco Products
  - Type
  - Amount

Personal Habits:

Do you drink alcohol? ☐ YES ☐ NO
If so, what type and how much?
Ever used illicit drug? ☐ YES ☐ NO
If so, when and what substance?
Do you have pets? ☐ YES ☐ NO
If so, what type and how many?
Have you traveled outside the US recently? ☐ YES ☐ NO
If so, when and where?

FAMILY HISTORY (Please mark **ALL** the apply)

If marked, please list all biological relatives with illness (example: mother, father, sister, uncle, grandparent, etc.).

Disease/Condition	Comments
☐ Asthma	
☐ Seasonal Allergies / Hay Fever	
☐ Eczema	
☐ Cystic Fibrosis	
☐ Alpha-One Antitrypsin Deficiency	
☐ COPD / Emphysema	
☐ Recurrent Pneumonias	
☐ Tuberculosis	
☐ Other Lung Disease(s)	
☐ Hives / Swelling	
☐ Heart Problems	
☐ Arthritis / Connective tissue diseases	
☐ Blood Clots	
☐ Diabetes	
☐ Strokes	
☐ Seizures	
☐ Thyroid disease	
☐ Other	
☐ Other	

What **SYMPTOMS** are you currently experiencing? (Please answer **YES or NO** for each symptom)

Yes	No	Symptom (circle if appropriate)	Severity (mild, moderate, severe)	How Often? (Hourly, daily, 2x week, etc.)	Comments
☐	☐	**Itchy eyes**			
☐	☐	**Runny nose**			
☐	☐	**Sneezing**			
☐	☐	**Hives/Rash**			
☐	☐	**Nasal congestion**			
☐	☐	**Sinus headache**			
☐	☐	**Sinus infections**			
☐	☐	**Shortness of breath**			
☐	☐	**Chest tightness**			
☐	☐	**Wheezing**			
☐	☐	**Cough**			
☐	☐	**Coughing up blood**			
☐	☐	**Nighttime shortness of breath**			
☐	☐	**Sleeping Problems** ☐ **Snoring** ☐ **Restless sleep** ☐ **Insomnia** ☐ **Stopping breathing** ☐ **Morning headaches**			

REVIEW OF SYSTEMS

What **SYMPTOMS** are you current experiencing? (Please answer **YES or NO** for each symptom)

Y	N		Comment	Y	N		Comment
Constitutional							
		Change in weight				Chills	
		Fever				Fatigue	
		Sweats				Night Sweats	
Skin							
		Nail Changes				Changes in Hair Growth	
Head, Eyes, Ears, Nose, Mouth, Throat							
		Headaches				Hoarseness	
		Changes in Vision				Change in hearing	
		Change in hearing				Nasal Polyps	
		Nose bleeds				Swallowing problems	
		Dizziness				Mouth sores	
Cardiovascular							
		Chest Pain				Heart murmur	
		Palpitations				Shortness of Breath When Lying Flat	
		Swelling in Ankles					
Gastrointestinal							
		Heartburn				Diarrhea	
		Abdominal Pain				Constipation	
		Nausea				Choking/Trouble Swallowing	
		Vomiting				Bloody Stools	
Genitourinary							
		Urinary Urgency				Urinating at night	
		Painful Urination				Broody urine	
		Difficulty Urinating				Incontinence	
Musculoskeletal							
		Joint Pain				Muscle Weakness	
		Joint Swelling				Stiffness	
		Muscle pain				Muscle Cramps	
Neurologic							
		Seizures				Concentration Problems	
		Numbness				Fainting	
		Weakness				Tremors	
		Tingling				Loss of coordination	
		Memory Problems					
Psychiatric							
		Change in Mood				Stress	
		Anxiety				Panic/Fear Attacks	
		Depression					
Hematologic							
		Easy Bleeding				Previous Transfusions	
		Easy Bruising				Swollen Glands	
		Blood Clots				Anemia	
Endocrine							
		Excessive thirst				High blood sugar	
		Thyroid Problems				Diabetes	

Please use the space provided for additional history or for other information that you would like us to know. Thank you for completing our Health History. We welcome you to our practice and look forward to meeting all your health care needs.
Sincerely,

Critical Care and Pulmonary Consultants, P.C.