Crouse
MEDICAL PRACTICE, PLLC

Pulmonary Disease Medical History Form

Name _____ Date of Exam _____

Age _____ Date of Birth _____

Reason for today's visit:_____

Who is your primary or family physician? _____

List all the physicians you see on a regular basis and the reason for this:

1. _____ 3. _____
2. _____ 4. _____

List all current and past health problems. □ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List Current Medications (Include inhalers, birth control) (List name, dose, frequency). □ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Check if you use any of the following devices. □ None

□ Oxygen Flow rate _____ L/min When do you use it?_____
□ CPAP or BiPAP (mask worn when sleeping)
□ Spacer with inhaler (aerochamber, ellipse, inspirese, etc.)
□ Nebulizer (breathing treatment via a machine)

List All Over-the-counter Medications or Supplements (Vitamins, natural herbs, etc.). □ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any Allergies to Medications (include IV contrast) or Foods and the Reaction. □ None

1. _____ 3. _____
2. _____ 4. _____

List All of Your Lifetime Surgeries and Major Injuries. □ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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List Hospitalizations other than for surgeries and illnesses listed above. □ None

1. _____ 3. _____

2. _____ 4. _____

Advanced Directives

Do you have an Advanced Medical Directive / Living Will? □ Yes □ No

Social History

Highest education level? Grade___ □ High School □ Vocational School □ College □ Graduate School

Marital Status? □ Married □ Single □ Divorced □ Widow/Widower

Do/did you smoke? □ Yes □ No Packs / day_____ How many years?_____

Have you ever quit? □ Yes □ No If yes, when and for how long did you quit? _____

How did you quit? _____

Do you use tobacco products other than cigarettes? □ Yes □ No

If yes, which ones? _____

Does anyone smoke in your household? □ Yes □ No

Do you drink alcohol? □ Yes □ No Amount per week_____

Have you ever used illegal substances? □ Yes □ No

Have you ever had a DUI or DWI? □ Yes □ No

Have you ever experienced difficulty with alcohol, drug, or other substance use? □ Yes □ No

Hobbies? (list) _____

Do you explore caves? □ Yes □ No

Pets (types)? _____

Do you take care of birds (pigeons, chickens)? □ Yes □ No

Recent Travel (where)? _____

Where did you grow up? _____

Did you live on a farm? □ Yes □ No

Occupational History

Current occupation _____

Please list previous occupations (include approximate dates of employment)

1. _____ 3. _____

2. _____ 4. _____

Exposures: List industrial/agricultural agents/fumes/chemicals to which you have had significant exposure

1. _____ 3. _____

2. _____ 4. _____

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Family History (blood related kin)

□ Adopted or do not know family history

If your mother or father is deceased, what caused his/her death? _____

If any of your siblings are deceased, what caused his/her death? _____

Please check if any of the following apply to blood related kin. Indicate which family member(s):

□ COPD / emphysema _____ □ Asthma _____

□ Tuberculosis _____ □ Cancer (what type?) _____

□ Heart disease _____ □ Diabetes _____

□ High blood pressure _____ □ Bleeding/clotting problem _____

□ Sleep disorders _____ □ Nasal / Sinus Disease _____

□ Other lung diseases (specify) _____

REVIEW OF SYSTEMS - Do you **CURRENTLY** or **FREQUENTLY** suffer from or have difficulty with any of the below? Please check box(es)

GENERAL
□ Unusual fatigue
□ Loss of appetite
□ Fevers or chills
□ Nights sweats (drench sheets/clothes)
□ Weight loss. How much? _____ lbs.
Over what time frame? _____
□ Weight gain. How much? _____ lbs
Over what time frame? _____
□ **None of the above**

EARS, NOSE, THROAT, MOUTH
□ Headache
□ Ear pain / pressure
□ Sinus problems, post nasal drip
□ Nasal congestion, runny nose
□ Hoarseness
□ Frequent need to clear throat
□ Ulcer of tongue or mouth
□ Sore throat
□ **None of the above**

CARDIOVASCULAR
□ High blood pressure
□ Chest pain on exercise (angina)
□ Irregular beat or palpitation of heart
□ Heart murmur
□ Swelling or edema of ankles
□ History of heart attack
□ History of enlarged heart (CHF)
□ **None of the above**

LUNGS (RESPIRATORY)
□ Asthma, wheezing
□ Cough for more than 3 weeks
□ Cough, new problem
□ Cough up blood
□ Chest tightness or discomfort
□ Tuberculosis / PPD + (positive skin test)
□ Exposed to tuberculosis
□ COPD / emphysema
□ Recurrent bronchitis
□ Shortness of breath
□ Exposure to asbestos or other occupational hazard
□ Required life support / mechanical ventilation (respirator)
□ **None of the above**

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ALLERGIC
□ Hay Fever
□ Frequent sneezing
□ Watery eyes
□ Seasonal allergies
□ **None of the above**

GLANDULAR (LYMPHATIC)
□ Swollen lymph nodes anywhere
□ **None of the above**

URINARY
□ Blood in urine
□ Kidney or bladder problems
□ **None of the above**

HEMATOLOGIC
□ Easy bleeding / bruising
□ Anemia (low blood count)
□ Ever had a blood clot in legs or lungs
□ Blood transfusion
□ **None of the above**

ENDOCRINE
□ Increased thirst, hunger
□ Sensitive to heat/cold
□ Change in skin, body hair
□ **None of the above**

MUSCLES AND BONES
□ Pains or swelling of joints
□ Morning stiffness
□ Leg or arm swelling
□ Arthritis
□ Sexually transmitted diseases
□ **None of the above**

RHEUMATOLOGIC
□ Hair loss
□ Joint pains or swelling
□ Muscle pain or weakness
□ Back or neck pain
□ Sharp pain when take a deep breath (pleurisy)
□ Dry eyes (eye irritation), dry mouth
□ Jaw pain or pain with chewing
□ Fingers that turn white and hurt in the cold (Raynaud's phenomenon)
□ **None of the above**

STOMACH AND BOWELS
□ Difficult or painful swallowing
□ Acid Reflux ("Heartburn")
□ Regurgitation
□ Belching
□ Hiatal hernia
□ Stomach ulcer / Intestinal ulcer
□ Abdominal pain
□ Nausea or vomiting
□ Vomit blood / Black bowel movements
□ Blood or mucous in the stool
□ Liver disease
□ Hepatitis
□ Jaundice
□ **None of the above**

SLEEP
□ Snoring
□ Stop breathing when sleeping
□ Fall asleep easily during the day
□ **None of the above**

SKIN
□ Rash
□ Tumor on skin
□ **None of the above**

NEUROLOGIC
□ Anxiety
□ Depression
□ Unusual dizziness, fainting, or loss of consciousness
□ **None of the above**

IMMUNIZATIONS (Check if have received the following)
□ Flu shot (influenza) Year: _____
□ Pneumovax Year: _____

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FOR PHYSICIAN (only) "I have personally reviewed and confirmed the above information."

Signature _____ Date _____