HOLY NAME PULMONARY ASSOCIATES, PC

PULMONARY DISEASE, *CRITICAL CARE MEDICINE AND ↑SLEEP MEDICINE

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UPDATED PATIENT MEDICAL HISTORY

Patient Name: _____ Age: _____ DOB: _____
Address: _____
_____
Occupation: _____
Marital Status: _____
Spouse's Name: _____
Mother's Name: _____
Father's Name: _____

Primary MD: _____
Referred By: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Emergency Contact Phone: _____

ALLERGIES TO MEDICATIONS, DYES OR OTHER SUBSTANCES? ____ NO ___ YES Latex Allergy? ___ NO ____YES
(If YES, please list name of medication and type of reaction)

_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS
(Please circle "Y" if you have had problems with or are presently complaining of any of the following. If not, please circle "N'.)

1. High blood pressure	Y N	10. Constipation	Y N	19. Hepatitis/jaundice	Y N	28. Anemia	Y N
2. Diabetes	Y N	11. Diarrhea	Y N	20. Thyroid Disease	Y N	29. Alcohol Abuse	Y N
3. Cancer	Y N	12. Blood in stool	Y N	21. Headache	Y N	30. Drug Abuse	Y N
4. Heart disease	Y N	13. Ulcers	Y N	22. Kidney disease	Y N	31. Eating Disorder	Y N
5. Chest pain/ tightness	Y N	14. Abdominal discomfort	Y N	23. Difficulty urinating	Y N	32. Eyes	Y N
6. Frequent urination	Y N	15. Change in weight	Y N	24. Blood disorders	Y N	33. Ears nose mouth throat	Y N
7. Rheumatic fever	Y N	16. Hemorrhoids	Y N	25. Venereal diseases	Y N	34. Musculoskeletal	Y N
8. Asthma	Y N	17. Gall bladder disease	Y N	26. Anxiety	Y N	35. Skin	Y N
9. Change in bowel habits	Y N	18. Colitis	Y N	27. Depression	Y N	36. Other	Y N

NEW SURGERIES SINCE LAST VISIT:

Surgery	New Hospitalizations Since Last Visit
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

When was your last:
Pap Smear? _____ Breast Exam? _____ Colonoscopy? _____
Mammogram? _____ Cholesterol Check? _____ Bone Density Test? _____

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FAMILY HISTORY

(Has any member of your family ever had the following:)

Illness			Which family member?	Age when diagnosed
Cancer:	[ ] No	[ ] Yes (describe type) _____		
Breast Cancer:	[ ] No	[ ] Yes		
Ovarian Cancer:	[ ] No	[ ] Yes		
Uterine Cancer:	[ ] No	[ ] Yes		
Colon Cancer:	[ ] No	[ ] Yes		
High Blood Pressure:	[ ] No	[ ] Yes		
Heart Disease:	[ ] No	[ ] Yes		
Diabetes:	[ ] No	[ ] Yes		
Stroke:	[ ] No	[ ] Yes		
Bleeding Diseases:	[ ] No	[ ] Yes		
Other:				

Mother: _____

Father: _____

Siblings: _____

Ancestry: [ ] Jewish [ ] Black [ ] Mediterranean [ ] Other _____

PRESCRIPTION MEDICATIONS / OVER-THE-COUNTER MEDICATIONS / VITAMINS

(Please list any prescription medication you take on a regular basis:)

Drug Name	Dose	Drug Name	Dose

PREVENTION

Do you smoke cigarettes?	[ ] No	[ ] Yes	If yes, packs per day:	
Do you drink alcoholic beverages?	[ ] No	[ ] Yes	If yes, drinks per week:	
Do you drink coffee or tea?	[ ] No	[ ] Yes	If yes, cups per day:	
Do you use recreational drugs (marijuana, cocaine, crack, etc.)?	[ ] No	[ ] Yes	If yes, list type and frequency:	
Have you ever engaged in any activity which has put you at risk of getting AIDS?	[ ] No	[ ] Yes	If yes, explain:	
Do you wish to be tested for AIDS?	[ ] No	[ ] Yes		
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	[ ] No	[ ] Yes		
Do you ever feel afraid of your partner?	[ ] No	[ ] Yes		

M.D. ONLY:

DOCTOR'S SIGNATURE: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____