SUBURBAN LUNG ASSOCIATES ***History Form***

PATIENT NAME _____ Date_____ Sex M F

Current Medications

Name	*Dose*	*Frequency*	*Name*	*Dose*	*Frequency*

Allergies to Medications	*Type of Reaction*	*Allergies (Other)*	*Type of Reaction*

Past Medical History

Medical Problem	*Date*	*Surgical Procedure*	*Date*

Hospitalization	*Location*	*Date*

Tests and Immunizations

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

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

Current Physicians

Name	*Number*	*Specialty*

Family History

System	Diseases	Family Member/Age
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
Electronic cigarettes 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 _____