

# Concord Pulmonary Medicine Medical History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

List any known medical problems that you have received treatment for by a health care provider.

- |    |     |
|----|-----|
| 1. | 6.  |
| 2. | 7.  |
| 3. | 8.  |
| 4. | 9.  |
| 5. | 10. |

Surgeries:

- |    |    |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Medications: (Please list all medications you are currently taking and the dosage.)

- |    |    |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

ALLERGIES: 1. \_\_\_\_\_ Reactions 1. \_\_\_\_\_  
2. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 3. \_\_\_\_\_

To your knowledge, have any of the following tests ever been done? (If yes, list dates when done if possible)

EEG (electroencephalograph/brain wave test)	No _____	Yes _____
Thyroid studies	No _____	Yes _____
Psychiatric Exam	No _____	Yes _____
CT or MRI Scans (brain)	No _____	Yes _____
Sleep Study	No _____	Yes _____

Have you had any of the following problems? (check all that apply)

Seizures/convulsions	High blood pressure (hypertension)
Lung/breathing problems	Heart Disease
Diabetes (high blood sugar)	Stroke or "mini stroke"
Thyroid problems	Brain infection (meningitis/encephalitis)
Head injury with loss of consciousness or concussion	

Do you drink alcohol? Yes No

If yes, how many alcoholic beverages do you average each day \_\_\_\_\_ or each week \_\_\_\_\_.

Have you or others ever felt that alcohol was a problem for you? Yes No

Do you use caffeine (coffee/tea/soda/chocolate)? Yes No

How many 8 oz. cups per day? \_\_\_\_\_ Any after 4:00 PM? \_\_\_\_\_

Do you use tobacco products? Yes No

If yes, please indicate what type and how much. \_\_\_\_\_

Height \_\_\_ ft \_\_\_ in. Current weight \_\_\_ lbs. Weight one-year ago \_\_\_ lbs. Maximum Weight \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Illnesses: Check those, which apply.**

- Scarlet fever or rheumatic fever \_\_\_\_\_
- Pneumonia or bronchitis \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_
- Whooping Cough \_\_\_\_\_
- Asthma \_\_\_\_\_
- Emphysema \_\_\_\_\_
- Hives or Eczema \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Heart Attack \_\_\_\_\_
- Heart Failure \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Rheumatism \_\_\_\_\_
- Cancer \_\_\_\_\_
- Stomach ulcers or indigestion \_\_\_\_\_
- Thyroid Disease \_\_\_\_\_
- Depression \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Any other illnesses \_\_\_\_\_

TB (Tine or PPD) Skin test Date: \_\_\_\_\_ Results \_\_\_\_\_  
Last Flu Vaccine Date: \_\_\_\_\_  
Last Pneumonia vaccine \_\_\_\_\_  
HIV Testing \_\_\_\_\_

**Personal:**

Smoker \_\_\_\_\_ Ex-smoker \_\_\_\_\_ Packs per day \_\_\_\_\_  
Years of Smoking \_\_\_\_\_ Year Quit \_\_\_\_\_  
Exercise \_\_\_\_\_ How many times per week \_\_\_\_\_

**Family History:** State age and health if living or age at death and cause of death, if deceased.

Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Brother: \_\_\_\_\_  
Sister: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
Other: \_\_\_\_\_

**Social History:**

Occupation present \_\_\_\_\_ Past \_\_\_\_\_  
Marital Status: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ Occupation \_\_\_\_\_  
Hobbies/Interest: \_\_\_\_\_

**Recent symptoms:**

- Do you now have or have you had within the past year:
- Fainting Spells? \_\_\_\_\_
  - Dizziness? \_\_\_\_\_
  - Recurrent nose bleeds? \_\_\_\_\_
  - Sinus problems? \_\_\_\_\_
  - Hay fever? \_\_\_\_\_
  - Persistent hoarseness? \_\_\_\_\_
  - Chest pain? \_\_\_\_\_
  - Abnormally rapid heart beat/palpitations? \_\_\_\_\_
  - High blood pressure? \_\_\_\_\_
  - Coughed up blood? \_\_\_\_\_
  - Chronic or frequent cough? \_\_\_\_\_
  - Unexplained fever? \_\_\_\_\_
  - Night sweats? \_\_\_\_\_
  - Shortness of breath on:
    - Walking several blocks? \_\_\_\_\_
    - One flight of stairs? \_\_\_\_\_
    - Lying down? \_\_\_\_\_
  - Swelling of hands and/or feet? \_\_\_\_\_
  - Leg cramps walking or at night? \_\_\_\_\_
  - Recurrent stomach pain? \_\_\_\_\_
  - Heartburn? \_\_\_\_\_
  - Vomited blood? \_\_\_\_\_
  - Swelling of joints/pain in the joints? \_\_\_\_\_
  - Numbness or weakness of hands/feet? \_\_\_\_\_
  - Skin rash? \_\_\_\_\_

**Please bring all your current medications to your appointment.**

**After your Primary Care Physician has submitted a request to our office, to set up a specialty consultation appointment.**

Complete and mail this form to:

Pulmonary Medicine  
248 Pleasant Street, Suite G-100,  
Concord, NH 03301  
603-224-9661

