BUXMONT PULMONARY AND SLEEP MEDICINE

MEDICAL HISTORY DOB:

PATIENT INFORMATION

Full Name:

Last *First* *M.I.*

Address:

Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Home Phone: ( ) Email Address:

Allergies to Medications:

Reason For Visit or Chief Complaint

Racial or Ethnic Group

☐ American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black/African American

☐ Hispanic/Latino ☐ White/Caucasian ☐ Other

Marital Status: Single__ Married__ Divorced__ Widowed__ Separated__

☐ Female ☐ Male

Present Medical History

Please check off if you have had any of the problems listed below

Emphysema/COPD	Bronchitis	Asthma
Tuberculosis	Pneumonia	Hay Fever
High Blood Pressure	Heart Disease	Chest Pain/Tightness
Diabetes	Gall Bladder Disease	Hepatitis
Cancer	Thyroid Disease	Colitis

Kidney Disease/Stones	Prostate Problems	Other(specify)
Operations (specify)	**Hospitalized** (specify)	**Immunizations** (dates) ○ Tetanus_____ ○ Flu_____ ○ Hepatitis B_____ ○ Pneumovax_____

Family History	**Which Family Member**	**Approximate Age at Diagnosis**
Cancer		
High Blood Pressure		
Heart Disease		
Diabetes		
Strokes		
Mental Disease		
Asthma		
Bleeding Disease		
Other:		

Medications (Please List Current Medications)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you or did you smoke? No: Yes:

(If yes, how many packs per day?)_____How many yrs?____

(If you quit, when?)_____Years

Have you ever worked with chemicals, asbestos, paints or other hazardous substances? No: Yes:

Do you drink alcohol? No: Yes: (if yes, how many per day?)_____

Do you have any pets? No: Yes: (if yes, what kind of pet?)_____Do you use drugs(marijuana, cocaine, crack etc?) No: Yes: (If yes, explain)_____