Sparks Lung Center - New Patient Medical History Questionnaire

Patient Name_____Date of Birth_____

Past Medical History: (Circle all conditions that are currently or were previously present)

Diabetes	Hypertension	Heart Disease
Cancer	Tuberculosis	Rheumatic Fever
Kidney Disease		Gout
	None of the Above	

Surgeries: (List all operations and the approximate date of each procedure)

Hospitalizations:

Habits:

Smoking

_____Never smoked _____Used to smoke. Quit date _____

Use of other tobacco products _____No _____Yes If yes, what type _____

_____Currently Smoke, # of packs _____per day _____per week

Alcohol

___Never ___Yes, Type_____

Current Medications: (List all prescription and nonprescription medication and frequency they are taken*)*

** A list may be attached*

Allergies: (List medication and type of reaction)

Immunizations: Tetanus: _____date Pneumonia vaccine: _____date

Exercise: Type and frequency of routine exercise

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Patient Name_____**Date of Birth**_____

Family History: Please complete to the best of your knowledge.

	Living (L) or Deceased(D)	Current Age (or Age at Time of Death)	Major Medical Problems	Cause of Death (If Applicable)
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

Do you know of any blood relative who has or did have any of the following conditions?

YES NO

___ ___ Diabetes
___ ___ High Blood Pressure
___ ___ Heart Attack before the age of 65
___ ___ Other types of Heart Problems
___ ___ Cancer
___ ___ Stroke
___ ___ Tuberculosis
___ ___ Migraine Headaches