SHORE PULMONARY, P.A.
PATIENT'S PERSONAL HISTORY FORM

Please take some time to complete this questionnaire. Please answer all questions completely as it is important to the treatment of your care. If you can't answer or do not understand any questions, please ask a staff member.

Name________________________ Age______ Date of Birth____________ Place of Birth______________________
Occupation_________________________Medical Doctor___________________________Today's Date___________
Previous Occupation____
Date of Last Physical Exam__________________________________ With Whom_____________________________
Why are you here today?____

Please answer each of the following questions by indicating which family members has or had a history of :

FAMILY HISTORY

Cancer including Leukemia Which Family member? ___________ N/A
Tuberculosis Which Family member? ___________ N/A
Diabetes Which Family member? ___________ N/A
Heart Disease Which Family member? ___________ N/A
High Blood Pressure Which Family member? ___________ N/A
Stroke Which Family member? ___________ N/A
Sleep Apnea Which Family member? ___________ N/A
Asthma Which Family member? ___________ N/A
Allergies Which Family member? ___________ N/A
Liver Disease Which Family member? ___________ N/A
Emphysema Which Family member? ___________ N/A
Stomach or Duodenal Ulcer Which Family member? ___________ N/A
Glaucoma Which Family member? ___________ N/A
COPD Which Family member? ___________ N/A
Bleeding Disorder Which Family member? ___________ N/A
(Clotting, Embolism, Thrombosis)

PERSONAL HISTORY

Do you smoke? No Yes
How much___________________
Did you ever smoke? No Yes
Quit Date________________
Are you or have you been exposed to 2nd hand smoke?
How often?_______When________
Do you drink? No Yes
How much?__________
How often?__________
Do you have problems sleeping? No Yes
Snoring? No Yes
Daytime Sleepiness? No Yes
Fatigue? No Yes
Falling asleep while driving? No Yes

IMMUNIZATIONS

Have you been immunized against:
Flu?____________________ Date/Year_____________
Pneumonia?_____________ Date/Year_____________
Tetanus?________________ Date/Year_____________

Have you ever had a positive reaction to a tuberculosis skin test? No Yes
When_________________Type of treatment, if any____

ALLERGIES

Are you allergic to any medication? No Yes If yes be specific______________________________

Are you allergic to any foods? No Yes If yes be specific______________________________

Name____________________________ Patient Personal History Form (Cont'd)

MEDICATIONS
Please list medications you are currently taking including dosage:

Medication	Dosage	Medication	Dosage

OPERATIONS
Have you ever had surgery:

Tonsils/ Sinus	No Yes When_______________	Thyroid/Neck	No Yes When________________
Appendix	No Yes When_______________	Lungs	No Yes When________________
Gall Bladder	No Yes When_______________	Breast	No Yes When________________
Stomach	No Yes When_______________	Heart/Bypass/Pacemaker	No Yes When________________
Colon/Bowel	No Yes When_______________	Other (Be Specific)	No Yes When________________
Orthopedic/Hip/Knee,etc.	No Yes When_______________		

DIAGNOSED DIFFICULTIES:
Do you now, or have you in the past, had any of the following:

Epilepsy/convulsion	No If Yes - Current or History of	Rheumatic Fever	No If Yes - Current or History of
Stroke	No If Yes - Current or History of	Angina	No If Yes - Current or History of
Glaucoma	No If Yes - Current or History of	Cirrhosis of Liver	No If Yes - Current or History of
Asthma	No If Yes - Current or History of	Digestive Disease	No If Yes - Current or History of
Hay fever	No If Yes - Current or History of	Anemia	No If Yes - Current or History of
Emphysema	No If Yes - Current or History of	Diabetes	No If Yes - Current or History of
Tuberculosis	No If Yes - Current or History of	Thyroid Disease	No If Yes - Current or History of
Abn Chest X-ray	No If Yes - Current or History of	Hypothyroid	No If Yes - Current or History of
Heart Disease	No If Yes - Current or History of	Hyperthyroid	No If Yes - Current or History of
Arrhythmia	No If Yes - Current or History of	Phlebitis/Embolism	No If Yes - Current or History of
Sleep Apnea	No If Yes - Current or History of	Cholesterol Disorder	No If Yes - Current or History of
Varicose Veins	No If Yes - Current or History of	High Blood Pressure	No If Yes - Current or History of
Ear Infection/sinus	No If Yes - Current or History of	Stomach/Duodenal Ulcer	No If Yes - Current or History of
Chronic Bronchitis	No If Yes - Current or History of	Depression/Anxiety Disorder	No If Yes - Current or History of

SYSTEM REVIEW
Do you have any of the following complaints?

Fever	No Yes	Night Sweats	No Yes
Aches/Pains	No Yes	Swollen ankles	No Yes
Swollen glands	No Yes	Poor appetite	No Yes
Chills	No Yes	Indigestion/Heartburn	No Yes
General Weakness	No Yes	Difficulty swallowing	No Yes
Ear Pain	No Yes	Nausea or Vomiting	No Yes
Sinus trouble/Pain	No Yes	Abdominal pain or Cramps	No Yes
Persistent Hoarseness	No Yes	Change in bowel habits	No Yes
Severe Headache	No Yes	Breast lump	No Yes
Lumps in Neck	No Yes	Discharge from nipple	No Yes
Shortness of Breath	No Yes	Snoring	No Yes
Chest Pain/Pressure	No Yes	Daytime Somnolence	No Yes
Frequent Cough	No Yes	Wheezing	No Yes
Coughing Up Blood	No Yes	Poor exercise Unusual Heartbeat	No Yes

☐ Discussed with Patient to follow-up non-pulmonary issues with PCP or appropriate specialist.