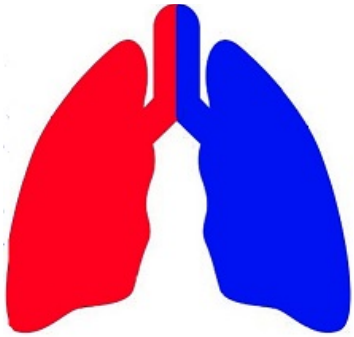

PULMONARY CONSULTANTS

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Birth Date: _____

Referring Physician: _____ Today's Date: _____

PLEASE CHECK ANY CONDITION THAT REPRESENTS SIGNIFICANT PROBLEMS FOR YOU

☐ Fever	☐ Weight Change	☐ Frequent Colds	☐ Hearing Loss
☐ Cough	☐ Shortness of breath	☐ Anxiety	☐ Runny/Stuffy Nose
☐ Cough With Phlegm	☐ Fatigue	☐ Difficulty Swallowing	
☐ Hoarseness	☐ Snoring	☐ Memory Loss	

PLEASE CHECK ANY CONDITIONS YOU HAVE BEEN DIAGNOSED WITH BELOW:

☐ Lung Nodule	☐ Emphysema	☐ Pulmonary Embolism	☐ Hepatitis B
☐ Lung Cancer	☐ Pulmonary Hypertension	☐ Heart Disease	☐ Seizure Disorder
☐ Sarcoidosis	☐ Pneumonia	☐ Kidney Disease	☐ Positive TB
☐ Pulmonary Fibrosis	☐ Chronic Bronchitis	☐ Macular Degeneration	☐ Lupus
☐Asthma	☐ Fluid On The Lungs	☐ Glaucoma Stroke	☐ Anemia
☐ COPD	☐ Sleep Apnea	☐ Asbestos Exposure	☐ Hypertension
☐ Hyperlipidemia	☐ Cancer	☐ Rheumatoid Arthritis	☐ Osteoporosis
☐ Osteopenia	☐ Liver Disease	☐ Hypothyroidism	☐ Diabetes
☐ Congestive Heart Failure			

ALLERGIES

Food Allergies: _____

Drug Allergy and Reactions :

_____
_____
_____
_____

ENVIRONMENTAL ALLERGIES

☐ CATS ☐ ANIMAL ☐ POLLEN ☐ TREES ☐ DUST ☐SMOKE

☐ DOGS ☐ DANDER ☐ GRASS ☐ MOLD ☐ PERFUME ☐ BLOOMING PLANTS

☐ CITRUS TREES ☐ OLIVE TREES

VACCINATIONS

☐ Flu Vaccine Date of Last Injection: _____

☐ Shingles Vaccine Date of Last Injection: _____

☐ Pneumonia 23 Vaccine Date of Last Injection: _____

☐ Prevnar 13 Pneumonia Shot Date of Last Injection: _____

☐ DTAP Date of Last Injection: _____

PLEASE LIST ALL SURGERIES AND YEARS

_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

PLEASE LIST ALL MEDICATION DOSAGE AND FREQUENCY BELOW

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Alcohol Use - ☐ Never ☐ Occasionally ☐ Daily Type:_____

Tobacco Use- ☐ Never ☐Previously, but quit-year_____ Packs Per Day_____for _____years

Drugs Use- ☐ Never ☐ Occasionally ☐ Daily Type:_____

Do you use illegal drugs?_____

Do you use Marijuana?_____

What is your occupation?_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐Divorced ☐ Separated

Name of spouse or significant other:_____

Children: Number of Children_____

Where were you born?_____

How long have you lived in Arizona?_____

Would you like access to your medical record online?_____

Please list other doctors you visit

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

PLEASE INDICATE THE CURRENT STATUS OF YOUR IMMEDIATE FAMILY MEMBERS

	Age	Date of Death	Cause
MOTHER			
DAD			
BROTHERS			
SISTERS			
GRANT PARENT			
AUNT			
UNCLE			
CHILDREN			

ADDITIONAL COMMENTS: