MAINLAND PULMONARY ASSOCIATES

NAME: _____ AGE:_____ DATE OF BIRTH: ___/___/_____
OCCUPATION:_____ PERSON WHO REFERRED YOU: _____
TODAY'S DATE:_____ _____
MARITAL STATUS: Married Single Widowed Separated Divorced

HISTORY OF PRESENT ILLNESS: (leave this blank, the doctor will discuss with you)

FAMILY HISTORY:

Have you or any member of your family had any of the following?:

			WHAT RELATIVE	/	*YOURSELF*
Cancer, Leukemia	NO	YES			
TB	NO	YES			
Diabetes	NO	YES			
Stroke	NO	YES			
Heart Attack	NO	YES			
High Blood Pressure	NO	YES			
Congestive Heart Failure	NO	YES			
Chest Pain (Angina)	NO	YES			
Irregular heart beat	NO	YES			
Epilepsy	NO	YES			
Bleeding Disorder	NO	YES			
Clotting Disorder	NO	YES			
Asthma	NO	YES			
Migraine Headaches	NO	YES			

			WHAT RELATIVE / *YOURSELF*	
Sleep Apnea	NO	YES	_____	_____
Emphysema	NO	YES	_____	_____
Stomach or Duodenal Ulcer	NO	YES	_____	_____
Kidney Disease	NO	YES	_____	_____
Sickle Cell Anemia	NO	YES	_____	_____
Anemia	NO	YES	_____	_____
Mental Illness	NO	YES	_____	_____
Suicide	NO	YES	_____	_____
Other Serious Diseases	NO	YES	_____	_____
Seizure (Epilepsy)	NO	YES	_____	_____
HIV/AIDS Autoimmune	NO	YES	_____	_____

	Age If Living	**Age Died**	**Cause of Death**
Father			
Mother			
Brothers			
Sisters			
Children			

PERSONAL HISTORY:

Do you drink alcohol? **YES** **NO**

How much alcohol do you drink on the average? _____ per day _____ per week

Are you on a special diet? YES / NO What diet?_____

Have you recently gained or lost weight? Gained:_____ Lost:_____ Neither:_____

ALLERGIES;

Are you allergic to any oof the following?

Penicillin	YES	NO	Reactions:_____
Sulfa	YES	NO	Reactions:_____
Bactrim	YES	NO	Reactions:_____

List other allergies to medications or food:_____

_____

MEDICATIONS:

List all medications currently taking:

NAME:	STRENGTH:	HOW OFTEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES/OPERATIONS:

Have you had any of the following operations?

	NO	**YES**	**DATE**	**TYPE OF SURGERY**
Appendix	_____	____	_____	_____
Breast	_____	____	_____	_____
Colon	_____	____	_____	_____
Gallbladder	_____	____	_____	_____
Hernia (rupture)	_____	____	_____	_____
Hemorrhoids	_____	____	_____	_____
Kidney	_____	____	_____	_____
Ovaries	_____	____	_____	_____
Prostate	_____	____	_____	_____
Small Intestine	_____	____	_____	_____
Stomach	_____	____	_____	_____
Thyroid	_____	____	_____	_____
Tonsils	_____	____	_____	_____
Other surgery	_____	____	_____	_____
Other hospitalizations	_____	____	_____	_____

SYSTEMS REVIEW:

Do you have any of the following complaints?

GENERAL	**NO**	**YES**	**N/A**	**KIDNEY**	**NO**	**YES**	**N/A**
Fever				Kidney stones			
General weakness				Blood in urine			
Memory loss				Pain or burning while urinating			
Easy bruising				Difficulty passing urine			
Diabetes				Getting up at night to urinate			
				Other			
HEAD							
Trouble with vision				**WOMEN**			
Trouble with ears				Breast lump			
Sinus problems				Discharge from nipple			
Persistent hoarseness				Vaginal discharge			
Severe Headaches				Vaginal bleeding or spotting (not w/ periods)			
Other				Hot Flashes			
				Possibly pregnant			
SKIN				Other			
Changing mole							
Rash				**MEN**			
Other				Prostate trouble			
				Discharge from penis			
NECK				Sore on penis			
Swelling				Lump in Testicles			
Lumps				Difficulty having erections			
Stiffness				Other			
Pain							
Other							

	NO	YES	N/A		NO	YES	N/A
CHEST, HEART AND LUNGS				**NEUROMUSCULAR**			
Shortness of breath				Dizzy spells			
Poor exercise tolerance				Fainting spells			
High blood pressure				Other			
Fluttering of heart							
Cheat pain or pressure attacks				**BONE/JOINTS**			
Frequent cough				Painful joints			
Wheezing				Swollen joints			
Night sweats				Loss of muscle strength			
Swollen ankles				Lump or swelling in muscles			
Other				Back pain			
				Other			
GASTROINTESTINAL							
Poor appetite				**MENTAL HEALTH**			
Indigestion or heartburn				Do you find you life:			
Difficulty swallowing				Satisfactory			
Nausea or vomiting				Boring			
Vomiting blood				Unsatisfactory			
Abdominal pain or cramps							
Diarrhea				Do you:			
Constipation				Cry easily			
Change in bowel habits				Feel anxious or upset			
Blood in stool/poop				Have difficulty with sleep			
Black, tar-like bowel movements/poop							
Other							