SOUTH BAY RESPIRATORY ASSOCIATES
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CONFIDENTIAL MEDICAL HISTORY

This questionnaire will help your doctor understand more about you and your medical problems.

Name _____

Number _____

Birthdate _____ Sex _____

Age _____ Date _____

PLEASE ANSWER EACH QUESTION AS CORRECTLY AS YOU CAN BY PLACING AN "X" IN APPROPRIATE BOX

WHAT IS THE **MAIN** REASON YOU ARE HAVING THIS EXAMINATION?

☐ (1) You are feeling ill or want medical advice. Describe your problem(s):

☐ (2) Checkup - No Special Complaints

_____

_____

_____

IN THE LAST **3 MONTHS** HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS:

	Yes	No
Frequent or severe headaches	☐	☐
Dizzy spells or blackouts	☐	☐
Trouble with your eyes or double vision	☐	☐
Trouble with your ears	☐	☐
Persistent hoarseness	☐	☐
Persistent cough	☐	☐
Coughing blood	☐	☐
Trouble breathing or shortness of breath	☐	☐
Heart trouble	☐	☐
Chest pain or pressure	☐	☐
High blood pressure	☐	☐
Trouble swallowing	☐	☐
Abdominal or stomach pain	☐	☐
Blood in bowel movement	☐	☐
Change in bowel habits	☐	☐
Diarrhea, frequent	☐	☐
Nausea or vomiting, frequent	☐	☐
Tired or rundown	☐	☐
Nervous, depressed or emotional trouble	☐	☐
Difficulty with urination	☐	☐
Kidney trouble or infections	☐	☐
Blood in urine	☐	☐
Pain in legs which forces you to stop walking	☐	☐
Pain or swelling in your joints	☐	☐
Thyroid trouble (goiter or swelling)	☐	☐

	Yes	No
Swollen glands	☐	☐
Unexplained weight loss (more than 5 lbs. in 3 months)	☐	☐
Increased thirst or urination	☐	☐
Allergies such as hay fever or asthma	☐	☐
Skin rash or changes in a mole	☐	☐
Easy bleeding	☐	☐

Other _____

_____

CHECK HERE ☐ IF NONE OF THE ABOVE

FOR WOMEN ONLY	Yes	No
Bleeding between periods	☐	☐
Vaginal bleeding, although you no longer have regular periods	☐	☐
Menopause	☐	☐
Vaginal discharge with burning or itching	☐	☐
Lump in breast not previously operated on	☐	☐
Discharge or blood from your nipples	☐	☐
Are you now pregnant?	☐	☐
Have you ever been pregnant?	☐	☐
If yes, how many children do you have? _____		
How many miscarriages or abortions? _____		
Do you take birth control pills?	☐	☐
Do you use other types of birth control?	☐	☐
If yes, what type? _____		
Are you still having menstrual periods?	☐	☐
If yes, when was your last period? _____		
If no, what age did they stop? _____		
Did your mother take hormones when she was pregnant with you?	☐	☐
When did you have your last pap test? _____		

	Yes	No
Do you have difficulty sleeping?	☐	☐
Are you concerned that you may be at risk for developing sexually transmitted diseases?	☐	☐
Do you have a loss of sexual interest or difficulty in performance that concerns you?	☐	☐
In the past year have you often found that your worries made you feel sick a lot?	☐	☐
In the past year has there been a death in your immediate family?	☐	☐
Are you now receiving care from a psychologist or psychiatrist?	☐	☐

	Yes	No
IN THE PAST YEAR HAVE YOU HAD ANY SERIOUS ILLNESS, SURGERY OR INJURY?	☐	☐

If yes, describe _____

_____

	Yes	No
IN THE PAST YEAR HAVE YOU BEEN HOSPITALIZED?	☐	☐

If yes, when and reason for hospitalization _____

_____

	Yes	No
HAVE YOU EVER HAD ANY RADIATION TREATMENT OR EXPOSURE?	☐	☐

MEDICATION HISTORY

LIST THE SPECIFIC NAME(S) OF THE MEDICATIONS YOU TAKE REGULARLY, THEIR STRENGTH AND HOW OFTEN. REFER TO THE LABEL ON YOUR MEDICINE CONTAINERS IF NECESSARY.

	NAME	STRENGTH	HOW OFTEN
1.			
2.			
2.			
4.			
5.			
6.			

WRITE IN THE NAMES OF ANY MEDICINES OR SHOTS TO WHICH YOU HAVE EVER HAD A BAD REACTION OR ALLERGY. IF NONE, PLEASE WRITE "NONE."

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

PAST MEDICAL HISTORY

HAS A **DOCTOR** EVER SAID YOU HAD ANY OF THE DISEASES OR CONDITIONS LISTED BELOW?

	Yes	No
Arthritis	☐	☐
Epilepsy (fits)	☐	☐
Stroke	☐	☐
Migraine Headaches	☐	☐
Glaucoma	☐	☐
Hypertension (High blood pressure)	☐	☐
Hay Fever	☐	☐
Heart murmur as an adult	☐	☐
Heart disease (coronary, infarct or angina)	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Emphysema of the lungs	☐	☐
Emotional problems	☐	☐
Gallstones or gallbladder problems	☐	☐
Liver disease (cirrhosis, hepatitis)	☐	☐
Stomach or duodenal ulcer	☐	☐
Colon or bowel disease	☐	☐
Kidney or bladder stones	☐	☐
Kidney or bladder infection	☐	☐
Venereal Disease (VD)	☐	☐
Anemia	☐	☐
Cancer or tumor	☐	☐
Diabetes	☐	☐
Gout	☐	☐
Thyroid disease	☐	☐
Psoriasis	☐	☐

Other (List)_____

_____

CHECK HERE ☐ IF NONE OF THE ABOVE **Go to Page 3**

AT THE PRESENT TIME MY HEALTH IS SUCH THAT: (Check only one)

I cannot do my usual work at all ..... ☐
I can work but am limited in amount or kind of work ..... ☐
I am not limited in my usual work ..... ☐

OPERATIONS	Year		Year
Appendix		Gallbladder	
Tonsils		Stomach	
Kidney		Other	
Colon (large bowel)			
Thyroid			
Breast		Uterus (womb)	
Hernia (rupture)		Tubal Ligation (tubes tied)	
		Any other operations? (List)	
Prostate			
Vasectomy			

WHEN WAS YOUR LAST IMMUNIZATION FOR TETANUS (Lockjaw)? _____

	Yes	No
HAVE YOU RECEIVED PNEUMOVAX VACCINE (to prevent pneumonia)?	☐	☐
HAVE YOU, IN THE PAST YEAR, HAD CLOSE CONTACT WITH ANYONE WHO HAD TUBERCULOSIS?	☐	☐

FAMILY HISTORY

IF ANY BLOOD RELATIVES HAVE HAD ANY OF THESE CONDITIONS, PLEASE CHECK WHO.

	Father	Mother	Other Relatives	Brother or Sister	Sons or Daughters
Cancer	☐	☐	☐	☐	☐
Which part of body? _____					
Diabetes	☐	☐	☐	☐	☐
Emphyserna	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Sickle cell anemia	☐	☐	☐	☐	☐
Suicide or mental illness	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Strokes	☐	☐	☐	☐	☐

SISTER AND BROTHERS

How many have you had? _____

If any are deceased, give age and cause of death:

AGE	CAUSE OF DEATH

Write in any conditions not listed above that run in your family: _____

PARENTS

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father			
Mother			

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PERSONAL HISTORY

Where were you born? _____

ARE YOU NOW:

( ) Married ( ) Number of marriages ( ) Never Married

( ) Divorced ( ) Widowed ( ) Separated

Do you have children? **Yes** ☐ **No** ☐ How many?_____What are their ages?_____

EDUCATION: Highest grade you completed:

( ) 0 - 9 ( ) 10 - 12 ( ) Tech./Bus. ( ) Partial college ( ) College Graduate ( ) Post Graduate

ARE YOU NOW HAVING SERIOUS OR DISTURBING PROBLEMS WITH YOUR:

( ) Marriage ( ) Family ( ) Drugs ( ) Job or employment ( ) Financial matters ( ) Other worries

OCCUPATIONAL INFORMATION

OCCUPATION _____

HAVE YOU EVER WORKED IN A PLACE WHERE YOU WERE OFTEN OR DAILY AROUND:

	Yes	No		Yes	No
Solvents or cleaning fluids	☐	☐	X-ray or radioactivity	☐	☐
Insect or plant sprays	☐	☐	Lead or metal dusts or fumes	☐	☐
Plastic or resin fumes	☐	☐	Very loud noises	☐	☐
Asbestos	☐	☐	Radar or microwave	☐	☐
Silica, sandblasting, grinding/drilling dust	☐	☐			

HABITS

Have you ever smoked cigarettes? Yes ☐ No ☐

Have you smoked cigarettes in the last ten (10) years? Yes ☐ No ☐

How many packs a day? _____

How long have you smoked? _____

Are you still smoking? _____

If not, when did you quit? _____

In the past year did you drink any alcohol? **Yes** ☐ **No** ☐

If yes, how many alcoholic drinks did you usually have (wine, beer, whiskey, cocktails)?

Total of 6 or more ( ) 1 or 2 a day ( )

3 to 5 a day ( ) Only occasionally ( )

Have you ever had a drinking problem for which you received treatment or which you got over by yourself **Yes** ☐ **No** ☐

	Yes	No		Yes	No
Do you think you drink too much alcohol?	☐	☐	Do you exercise regularly?	☐	☐
Do you use recreational drugs?	☐	☐	Do you follow a specific diet?	☐	☐
If yes, what kind?_____			If yes, what kind?_____		
Do you drink coffee, tea or cola drinks?	☐	☐			
If yes, how much? _____					

STOP HERE