YOUR NAME______________ ___________ ______________
FIRST NAME MIDDLE INITIAL LAST NAME
YOU'RE DATE OF BIRTH ____/____/____ AGE: __________

OTHER PHYSICIANS YOUV'E SEEN: ______________________________
REFERRED BY WHOM: ______________________________
WHERE DOES THE REFERRING PHYSICIAN PRACTICE: ______________________________?
IS THE PHYSICIANS LISTED ABOVE YOUR PRIMARY DOCTOR? (The dr. you see for overall medical care)

___ YES
___ NO
If NO what is you primary doctor's name? ______________________
Where does you primary physician practice? ______________________

Are there other doctors, not listed above, that you see on a regular basis who might be interested in knowing about the problem that brings you here?

___NO ___ YES (If YES please list these doctors' names and practice locations)

Name______________________________ Location______________________________

Name______________________________ Location______________________________

Name______________________________ Location______________________________

WHY HAVE YOU COME TO SEE US?

Please list the reason(s), symptom(s), or problem(s) that have led to your coming here. List the most important reason as #1

1.____

2.____

3.____

MEDICATIONS

It is important for us to know about **ALL** of the medications you are taking. "Over the Counter" (non-prescriptions) medicines may be just as important as prescription medicines. We need to know about the medicine regardless of it route of administration (swallowed, inhaled, injected, act.)

For each medicine, please list in the spaces provided its: NAME, DOSE, or amount taken (for example: number of mg. puffs, cc's, units) and SCHEDULE (for example: once a day, every 8 hours.)

	MEDICATION NAME:	DOSE:	SCHEDULE:
Medications by Mouth			
Inhaled Medicines:			
Skin Patch (trans-cutaneous)Meds:			
Nasal Spray or Drops:			

PAST MEDICAL HISTORY

Surgeries

Have you ever had any surgeries or operations?

___NO

___YES if yes please list surgeries below with approximate dates. (Be particularly careful to list any surgery involving the nose, sinuses, throat, neck, chest, heart, or lungs)

________________________________ in (year) ________
________________________________ in (year) ________
________________________________ in (year) ________
________________________________ in (year) ________
________________________________ in (year) ________
________________________________ in (year) ________
________________________________ in (year) ________

Medical Hospitalizations

Have you ever been hospitalized fir reasons other than surgery or childbirth?

__NO (If NO, please skip to Other Medical Problems)

__YES (If YES, please list below with approximate dates (be particularly careful to list all hospitalizations for Heart attacks, blood clots, pneumonia, bronchitis, and asthma.)

________________________________ in (year) ______
________________________________ in (year) ______
________________________________ in (year) ______
________________________________ in (year) ______

OTHER MEDICAL PROBLEMS

If you have ever been told that you had any of the following problems (that did not require hospitalization Pleas check and list the date when the problem was first noted.)

____Diabetes in (year) _____
____High Blood Pressure in (year) ____
____Heart Disease in (year) ____
_____Liver Disease in (year) ____
_____Thyroid Disease in (year) ____
_____Cancer in (year) _____

If you have had other serious medical problems that are not mentioned elsewhere, please list below with the date The problem was first noticed.

________________________________ in (year) ____
________________________________ in (year) ____

IMMUNIZATIONS

Have you ever had a pneumonia shot? (pneumococcal vaccine)

___NO ___UNCERTAIN ___YES: in about what year were you vaccinated? _____

Have you had a flu shot (influenza vaccine) within the last 9 months

___NO ___UNCERTAIN ___YES

Eye Drops:

Injections/"Shot":

Oxygen at home________________liters/minute flow.

Medications Allergies and Sensitivities:

Has aspirin ever seemed to bother your breathing?

___NO ___YES ___UNCERTAIN

Have you had problems with reactions to other medicines?

____NO (if NO, please skip to Past Medical History)

____YES (If YES, please list medicines that have bothered you and also list the type of reaction you have to that drug (rash, trouble breathing, nausea, etc.)

Drug	Reaction	Drug	Reaction

SMOKING HISTORY

Have you ever regularly smoked cigarettes?

___NO (If NO, please skip to Work History)
___YES (If YES at what age did you first start smoking?) ______years old

Are you still smoking? ____YES ______NO If NO, at what age did you quit? _________

During the years you smoked what number of packs of cigarettes ON AVERAGE did you smoke each day?

1/2 1 1 ½ 2 2 ½ 3 3 ½ 4 4 ½ 5

WORK HISTORY

Have you ever been employed outside of the home?

___NO (If NO, Please skip to Respiratory System Review)
___YES (If YES, what type of work have you done most recently?)_______________________________

In what year did you first do this work? ______

Are you still working? _____YES
_____NO If not, when did you last work? _________________

What other kinds of work have you done for 5 or more years?

___________________________from ____to ___ ______________________from ____to _____

___________________________from____to____ ______________________from ____to_____

If you have done other work, even for a very brief time, that may have exposed you to inhaled dusts or fumes please list.

___________________________from____to____ ______________________from____to____

___________________________from____to____ ______________________from____to____

RESPIRATORY SYSTEM REVIEW

Shortness of breath (Dyspnea) Do you get short of breath when you walk or exert yourself?

____NO

____YES (If yes, please check the lowest level of exertion required to predictably bring on a sensation of uncomfortable breathing)

____no activity required; short of breath at rest
____very little exertion; getting dressed
____little exertion walking room to room
____moderate exertion; making a bed or walking a block
____moderately heavy exertion; carrying grocery bags or climbing two flights of stairs
____heavy exertion; walking fast up a long hill

SENSITIVITY TO INHALED MATERIALS
Is there anything that you have been around or inhaled that seems to make you wheeze, cough or get short of breath?

_____NO (If No, please skip to Trouble breathing lying down)
_____YES (If YES, please check all the items that bother you.)

_____cigarette smoke
_____colognes, perfumes
_____aerosol sprays
_____solvents
_____cleaning compounds
_____cold, dry air
_____hot, humid air
_____dogs
_____cats
_____trees
_____grass
_____ragwood
_____house dust
_____molds or mildew

Please list any other inhaled materials that seem to cause you trouble breathing.

____
____

TROUBLE BREATHING LYING DOWN (Orthopnea)
Do you have to prop yourself up in bed to breath comfortably (do you get short of breath if you try to lie down flat)?

_____NO (If NO skip to shortness of breath during sleep)
_____YES (If YES at about what angle do you have to sleep to be comfortable?)

___ 15 ___30 ___45

___60 _____90 (sitting straight up)

SHORTNESS OF BREATH DURING SLEEP (Nocturnal dispend)
Do you awaken from sleep during the night because of shortness of breath?

___NO (If NO please skip to cough)
___YES (If YES how many times a night, week or month does this happen?) _______times a ___________

What seems to relieve your breathing after you've awakened with shortness of breath?

_____using my inhaled medicine _____sitting or standing up _____just letting time pass

_____other ____

Cough – Do you have some cough most days?

____NO (If NO, please skip to have you ever coughed up blood)
____YES (If YES is your cough productive (do you cough up any mucus, phlegm or sputum?) ___NO ___YES
If YES about how much sputum do you usually cough up in the course of a 24-hour day? (This is often very difficult to estimate; just give your best guess)

____a teaspoon (5cc.s) or less ____a tablespoon (15cc.s) ____an ounce (30cc.s)

____1/4 cup (60cc.s) ____1/2 cup (120cc.s) ____a cup (240cc.s) or more

What color is the sputum most often?

____clear, white or foamy ___green ___yellow ____other________________

Have you ever coughed up any blood?

____NO ____YES

Tuberculosis – Have you ever had a skin test for tuberculosis?

____NO (If NO please skip to have you ever been exposed to tuberculosis)
____YES (If YES, have any of the T.B. skin tests been positive? (Did the skin test get red or sore? Was the person reading the test concerned?)

____NO when was your most recent skin test? _____

____YES when was the first time your skin test was ever read as positive? _____

Have you ever been exposed to tuberculosis?

____NO ____UNCERTAIN ____YES (If YES when were you exposed to T.B.?) _____

CHEST PAIN
Are you bothered by pain in your chest? ____NO ____YES

EARS, NOSE AND THROAT
Are you often bothered by a "runny" or "stuffy" nose? ____NO ____YES (If YES, do your symptoms vary from one season to another?
What season seems to be your worst? ________________________________

Do you think you have post nasal drip?
____NO ____YES

REFLUX
Do you have problems with heartburn ____NO ____YES?

Do you ever awaken at night with "sour brash" (acid, bitter-tasting stomach contents) in your throat or mouth?
____NO ____YES

SOCIAL/HABITS

Martial Status

____Never Married ____Married Now ____Divorced (now or in past) ____Widowed (now or in the past)

Do you live alone?

____NO ____YES

TRAVEL

Have you traveled outside of the state of Indiana within the last year?

____NO ____YES

ALCOHOL

____NO(If NO skip to Non-medical drugs)

____YES (If YES, how many ounces of alcohol(shots of hard liquo cans of beer or glasses of wine) do you typically drink each **day week, month, or year** ____**oz. each**______________

NON-MEDICAL DRUGS

Have you ever used intravenous "street drugs" or other "recreations "drugs like cocaine, marijuana, etc?

____NO ____YES

FAMILY HISTORY

Please check the problems which any of your close 'blood' relatives (grandparents, parents, brothers, sisters and children)

____weight change of more that 5 lbs. over the last 6 month
____fever, shaking, chills, sweats
____easy fatigue, lack of energy
____eyes
____ears or hearing
____swelling
____depression or anxiety
____bleeding which does not normally stop
____irregular or too fast heartbeat
____numbness or weakness
____abdominal pain, nausea, vomiting, bowel problems
____bladder or kidney problems
____dental abscesses or periodontal disease
____swallowing

The doctor will be asking you additional questions about your presenting symptoms or problems as well as some of the other problems you've indicated on this form. Is there anything else, not addressed above, that you would like the doctor to know about yourself or your general medical history?

____NO ____YES (Be prepared to talk with the doctor about these additional issues)

THANK YOU FOR COMPLETING THE HISTORY QUESTIONNAIRE!

FOR OFFICE USE ONLY

Height ______ in. Weight________lb.

B.P. _____/_____mmhg ( ) brachial, sitting Pulse ______/min Respirations______/min.