PULMONARY CONSULTANTS OF SWFL

HEALTH HISTORY

Patient Name:_____DOB:_____ Today's Date: _____

Reason for today's visit?_____

Are you allergic to any medicines? _____

Do/Did you smoke cigarettes? 0 Yes 0 No If so, how old were you when you started? _____

What year did you quit smoking? _____ What is/was the most you smoked daily? _____

Do you drink alcohol, if so list daily amount? _____ Do you have trouble sleeping at night? 0 Yes 0 No

Nutrition/Diet: 0 Poor 0 Average 0 Good 0 Excellent 0 Vegetarian Do you exercise, if so how often:_____

What medical conditions are you currently being treated for and how long have you been treated for this condition?

1_____ 4_____

2_____ 5_____

3_____ 6_____

Please list any surgeries/procedures you have had and the dates?

1_____ 4_____

2_____ 5_____

3_____ 6_____

Family History

Mother, did she have any major medical problems? _____

If deceased, approximate age and cause: _____

Father, did he have any major medical problems? _____

If deceased, approximate age and cause: _____

# of Brothers:_____ Any major medical problems?_____

# of Sisters:_____ Any major medical problems?_____

How many children do YOU have? _____ Any major medical problems? _____

Do you do any recreational drugs? _____Do you wear your seatbelt? _____